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Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1990

NATIONAL MEDICAL ENTERPRISES, INC.,

Petitioner,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. To invoke collateral estoppel or res judicata against the federal government, must the parties to a first lawsuit be identical to the parties to a second lawsuit or is it sufficient that some of the parties are the same and that the nonparties are in privity with one another?

2. May the Secretary of Health and Human Services disallow Medicare reimbursement for costs incurred by providers of health care services to *maintain* their corporate status and to raise *equity* financing for patient care activities while allowing reimbursement for similar costs incurred to *organize* a provider corporation and to raise *debt* financing for patient care activities?

LIST OF PARTIES AND RULE 29.1 LIST

The parties to the proceedings below were the petitioner, National Medical Enterprises, Inc., and certain of its wholly owned hospital subsidiaries, and the respondent Louis W. Sullivan, M.D., the Secretary of the Department of Health and Human Services. They continue to be the parties before this Court. National Medical Enterprises, Inc. is a publicly owned company and is the parent company of various wholly owned health care subsidiaries, including the wholly owned hospital subsidiaries involved in the proceedings below.

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Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, National Medical Enterprises, Inc. ("NME"), respectfully prays that a writ of certiorari issue to review the opinion of the United States Court of Appeals for the Ninth Circuit entered in the above entitled proceeding on October 10, 1990. As indicated below, NME's timely filed petition for rehearing before the Court of Appeals was denied on November 29, 1990.

OPINIONS BELOW

The opinion of the Court of Appeals for the Ninth Circuit is reported at 916 F.2d 542 (9th Cir. 1990), and is reprinted in the Appendix at 1-15.

The decision and judgment of the United States District Court for the Central District of California (Letts, J.) in favor of NME have not been reported. They are reprinted in the Appendix at 16-25.

The decision of the Provider Reimbursement Review Board, the expert tribunal established by Congress to resolve Medicare reimbursement disputes, which was also in favor of NME, and the Secretary's reversal of the Board's decision are reprinted in the Appendix at 26-54.

JURISDICTION

On behalf of itself and its wholly owned hospital subsidiaries, NME sought judicial review of the Secretary's reversal of the favorable Provider Reimbursement Review Board decision in the United States District Court for the Central District of California pursuant to 42 U.S.C. Section 1395oo(f). Following the granting of summary judgment in NME's favor, the Secretary appealed to the Court of Appeals for the Ninth Circuit pursuant to 28 U.S.C. Section 1291.

On appeal, the Ninth Circuit reversed the decision of the District Court on October 10, 1990. NME timely petitioned for rehearing. The petition for rehearing was denied on November 29, 1990. Appendix at 55.

The jurisdiction of this Court to review the final decision of the Ninth Circuit is invoked under 28 U.S.C. Section 1254(1).

STATUTES, REGULATIONS AND AGENCY GUIDELINES

This case involves reimbursement for health care services provided to Medicare patients under the Medicare reasonable cost system. The statutes requiring "providers" of health care services to be reimbursed for their reasonable direct and indirect costs of providing such services, 42 U.S.C. Section 1395f(b)(1) and 42 U.S.C. Section 1395x(v)(1)(A), are set forth in the Appendix at 56-58. Similarly, the applicable Medicare regulations of the Secretary and his guidelines and interpretations contained in the Medicare Provider Reimbursement Manual-I are also set forth in the Appendix at 66-93. The applicable statutes, regulations and Manual provisions are discussed briefly in the next section.

STATEMENT OF THE CASE

A. Medicare Overview

Under the Medicare program, providers of inpatient hospital services (and some other types of services) are reimbursed for their reasonable costs necessary in the efficient delivery of health services. The Secretary is statutorily mandated to reimburse hospitals (and, for example, skilled nursing facilities) for their direct and indirect costs of providing care. 42 U.S.C. § 1395x(v)(1)(A),

Appendix at 57-58. *See also* 42 C.F.R. § 413.9 [1989], Appendix at 66-68.

Among the various costs considered to be indirectly related to patient care which are required to be reimbursed under the statute and the Secretary's regulations are depreciation expense, 42 C.F.R. Section 413.134 [1989], return on equity capital for proprietary providers, 42 C.F.R. Section 413.157 [1989], and interest expense, 42 C.F.R. Section 413.153 [1989].

Nonprofit and proprietary multihospital organizations, such as NME, are common in the health care industry and are designated by the Secretary as "chain organizations." As the Medicare "home office" for its various owned hospitals, NME incurs certain "home office costs," which are expressly allowed by the Secretary under the guidelines of the Medicare Provider Reimbursement Manual-I ("PRM-I"). Home offices file annual Medicare cost statements which are audited by the Secretary's fiscal intermediaries. Allowable home office costs are eventually allocated to the Medicare cost reports of the individual providers of the home office, which are also audited by the fiscal intermediaries. *See* PRM-I §§ 2150 *et seq.*, Appendix at 79-88.

Among the home office costs expressly allowed by the Secretary are corporate *organization* costs and debt financing costs, such as interest on a loan to the extent the loan proceeds are used for patient care-related matters, such as acquiring hospital assets. *See* PRM-I §§ 2150.2B and D, Appendix at 82-83. Also allowed as reimbursable costs indirectly related to patient care are other debt financing costs, such as bond discount fees and related expenses, including underwriting, legal, accounting,

appraisal, registration and printing expenses. *See* PRM-I § 212.1, Appendix at 75.

Although the Secretary expressly includes in the definition of allowable corporate organization costs legal fees, accounting fees, corporate director and shareholder meeting expenses, and corporate registration fees, (PRM § 2134.1A, Appendix at 76), his Manual does not allow these same costs when they relate to the ongoing maintenance of a corporate home office or corporate provider. Moreover, the Secretary does not allow *equity* financing costs, such as underwriters' fees and commissions involved in the issuance of stock to raise money for the hospitals of a corporate home office or a single corporate hospital, while he allows the identical types of costs for debt financing. *See* PRM-I §§ 2134.1B, 2134.9, and 212.1, Appendix at 75, 76, 78. The Secretary contends that corporate maintenance costs (also known as stock maintenance costs) are not primarily related to patient care.

B. The Medicare Appeal Process

The Secretary contracts with fiscal intermediaries to audit annual home office Medicare cost statements and providers' Medicare cost reports. 42 U.S.C. § 1395h. Following such audits, fiscal intermediaries determine the amounts owing under the Medicare principles of reimbursement. For cost reporting periods ending on or after June 30, 1973, providers' challenges to fiscal intermediaries' determinations are heard initially by the Provider Reimbursement Review Board ("PRRB"), a panel of reimbursement experts. *See* 42 U.S.C. § 1395oo(h), Appendix at 64.

Providers which are commonly owned are statutorily required to file group appeals with the PRRB. Individual

providers with a common owner and a common issue are not permitted to maintain separate PRRB appeals in their own names. *See* 42 U.S.C. § 1395oo(f)(1), 42 C.F.R. § 405.1837(b) [1989]. Appendix at 62-63, 74. The Secretary may review a PRRB decision after which judicial review is available. In group appeals, venue is appropriate in the district court in which the greatest number of such providers are located or in the District Court for the District of Columbia. *See* 42 U.S.C. § 1395oo(f)(1).

The PRRB does not have jurisdiction over pre-June 30, 1973 fiscal year disputes. Rather, such disputes are processed through hearings before the Secretary's Medicare fiscal intermediaries. *See* 42 C.F.R. § 405.1809 [1989]. Judicial review of pre-June 30, 1973 cost reports is available only in the United States Claims Court (formerly the United States Court of Claims). *See Whitecliff v. United States*, 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977). The Claims Court has also asserted jurisdiction over post-June 30, 1973 cost report disputes when the PRRB lacks jurisdiction over a dispute. *See Mount Sinai Medical Center v. U.S.*, 13 Cl. Ct. 561 (1987).

C. The Facts

During its 1973-1979 fiscal years, NME was required to incur substantial costs in order to maintain its corporate status and the corporate status of its hospitals. The costs enabled NME to engage in equity financing, the proceeds from which were used to maintain and improve its hospitals' patient care facilities. Such costs included stock transfer agent fees, stock and exchange registration fees, and costs attributable to filings with the Securities

and Exchange Commission, stockholder meetings, and annual reports to stockholders pertaining to financial matters. Ninth Circuit Opinion, Appendix at 4.

Acting pursuant to PRM-I Sections 2134.1B and 2134.9, the Secretary's fiscal intermediary disallowed these costs incurred by NME. After unsuccessfully challenging the disallowances for the 1973 fiscal year before a Medicare fiscal intermediary hearing officer, who is bound by the PRM-I guidelines, NME and three of its hospitals sought judicial review of the 1973 dispute in the United States Claims Court. The Claims Court, following the binding precedent of *AMI-Chanco, Inc. v. United States*, 576 F.2d 320 (Ct. Cl. 1978), concluded that NME's corporate maintenance costs were indirectly related to patient care and held that the Secretary had improperly denied reimbursement for such costs. Although the Secretary had every opportunity to do so, he did not appeal the adverse Claims Court decision. Ninth Circuit Opinion, Appendix at 5.

The Secretary refused to abide by the final decision of the Claims Court for NME's subsequent fiscal years, the 1974-1979 fiscal years. Thus, NME was forced to pursue the identical corporate maintenance issue for its 1974-1979 fiscal years before the PRRB. Pursuant to 42 U.S.C. Section 1395oo(f), NME was required to pursue the case as a group appeal which was designated by the PRRB, and later by the Secretary, as *"In the Case of National Medical Enterprises, Inc. Group Appeal v. Aetna Life & Casualty Co.* [the fiscal intermediary]."

The PRRB, which is not bound by the Secretary's PRM-I guidelines, held that NME should be reimbursed

for its corporate maintenance costs and that the Secretary's policy of denying reimbursement for such costs was inconsistent with the Medicare statute and his policy of allowing corporate organization costs. Appendix at 44-45. The Secretary refused to abide by the Claims Court decision for the 1974-1979 fiscal years and reversed the PRRB's decision. Appendix at 47-54.

NME was thus required to file suit in the District Court for the Central District of California pursuant to 42 U.S.C. Section 1395oo(f), where it expressly incorporated by reference as parties each of the 18 hospitals affected by the Secretary's decision into its District Court complaint. The District Court, without deciding whether the Secretary was collaterally estopped from relitigating the corporate maintenance costs issue in the District Court, concluded that the corporate maintenance costs were necessarily incurred by NME in securing equity financing for the provision of inpatient services and that such costs were indistinguishable from other costs, such as debt financing costs, that were reimbursed by the Secretary. Appendix at 22.

In its decision, the Court of Appeals for the Ninth Circuit decided that (1) the Secretary could not be collaterally estopped based on the Claims Court decision because mutuality of estoppel was lacking, and (2) the Secretary's decision denying reimbursement for stock maintenance costs is rationally based and thus must be upheld. Appendix at 4-15.

REASONS FOR GRANTING THE WRIT

A. The Collateral Estoppel Question

1. The Ninth Circuit's Conclusion Regarding The Alleged Lack of Mutuality of Estoppel Conflicts, at Least in Principle, With the Decisions of This Court and the Courts of Appeals.

Because NME's Claims Court action pertaining to the 1973 fiscal year involved three of NME's hospital subsidiaries while the second lawsuit pertaining to the 1974-1979 fiscal years involved 18 of NME's hospital subsidiaries (15 hospital subsidiaries in addition to those involved in the 1973 dispute), the Court of Appeals for the Ninth Circuit concluded that mutuality of estoppel was lacking. Thus, the Secretary was permitted to relitigate the corporate maintenance costs issue against NME in the Ninth Circuit. *See* Ninth Circuit Opinion, Appendix at 7-10. According to the Court, the facts that NME was involved in both lawsuits and that NME and its wholly owned subsidiaries are in privity with one another are not sufficient to establish mutuality of estoppel. Ninth Circuit Opinion, Appendix at 8.

This conclusion is directly contrary to the holdings of this Court and other Courts of Appeals which have held that the principle of collateral estoppel applies to preclude relitigation of an issue with the same party *or its privies*. *See Parklane Hosiery Co., Inc. v. Shore*, 43 U.S. 320, 326 (1979).

Indeed, in *Montana v. United States*, 440 U.S. 147 (1979), this Court precluded the federal government from relitigating an issue of law against a private party because the issue had been previously litigated in a state

court proceeding by an individual contractor whose litigation had been totally financed and controlled by the federal government. According to the Court, the United States plainly had a sufficient laboring oar in the state court litigation to constitute a party in all but a technical sense and thus the Court held mutuality existed. *See* the discussion of the *Montana* reasoning in *United States v. Mendoza*, 464 U.S. 154, 164, n.9 (1984).

The lower courts have also held that a wholly owned subsidiary and its parent company are in privity with one another for purposes of invoking collateral estoppel and *res judicata*. *See Pan American Match, Inc. v. Sears Roebuck & Company*, 454 F.2d 871, 874 (1st Cir. 1972); *Astron Industrial Associates, Inc. v. Chrysler Motors Corp.*, 405 F.2d 958, 961 (5th Cir. 1961).

In the context of Medicare reimbursement, NME's relationship to its wholly owned hospital subsidiaries goes well beyond simple privity. NME was designated by the PRRB and by the Secretary as *the* party to represent the hospitals in the administrative proceedings. NME was statutorily required to pursue the corporate maintenance costs issue as a Medicare group appeal. NME incurred the corporate maintenance costs as the providers' home office and the costs were claimed in NME's home office cost statements for each fiscal year. If this were not enough, the Secretary's own regulation, 42 C.F.R. Section 405.1843 [1989], expressly states that an organization "related to a provider" is an appropriate party to a PRRB hearing. Thus, there is absolutely no basis for arguing that NME's presence in this case somehow destroys mutuality. In fact, NME's presence, together with the

presence of the three hospitals in both actions, assured mutuality.

Significantly, when the situation is reversed and the Secretary *prevails* in the first lawsuit, the Secretary has argued, and the lower courts have accepted, that a Medicare home office/parent company may bind its wholly owned subsidiaries in Medicare reimbursement disputes. Indeed, in another Medicare case involving reimbursement for corporate maintenance costs, the very same issue here, the Secretary, after prevailing in a first lawsuit, asserted that collateral estoppel may be applied (and thus argued that mutuality existed) so long as the parent company and Medicare corporate home office of certain hospitals was a party to both lawsuits. *See* excerpts from the Secretary's Memorandum of Points and Authorities in *Humana, Inc. v. Richard S. Schweiker*, Civ. No. C82-2072-AJZ, Appendix at 96-103. *See also Humana, Inc., etc., et al. v. Schweiker*, (N.D. Tenn. 1983) [1983 Transfer Binder] Medicare and Medicaid (CCH) ¶ 32,912, Appendix at 106-118, where, at the urging of the Secretary, the Court applied collateral estoppel against the wholly owned subsidiaries of a hospital company to preclude relitigation of a Medicare reimbursement issue resolved favorably to the Secretary in an earlier lawsuit even though some of the wholly owned hospital subsidiaries were not named as parties in the earlier lawsuit.

The only difference between the *Humana* proceedings and the within proceedings is that the Secretary prevailed in the first lawsuits in the *Humana* cases but lost in the first lawsuit in the within proceedings. The outcome of the first lawsuit should have no effect on whether mutuality exists for purposes of collateral estoppel.

In short, mutuality clearly existed here since if NME and its three hospitals had been *unsuccessful* in the Claims Court proceedings, the Secretary could have precluded NME and any or all of its wholly owned subsidiaries from relitigating the corporate maintenance issue in subsequent lawsuits against the Secretary.

Before moving to a discussion of the importance of the collateral estoppel issue, NME responds briefly to the Ninth Circuit's conclusion that collateral estoppel has been disfavored by the Supreme Court in circumstances such as those in this case. *See* Ninth Circuit Opinion, Appendix at 9. Contrary to the Ninth Circuit's opinion, the fact that NME could obtain a judgment in one circuit and bind the Secretary in another circuit if collateral estoppel were applied has not been disfavored by this Court when the parties are the same or in privity. The Supreme Court has only disfavored such a result in cases involving *nonmutuality* where the government would be forever thwarted from relitigating important issues against *all* other parties once an unfavorable decision was issued by a Court of Appeals. The Supreme Court has stated:

> The concerns underlying our disapproval of collateral estoppel against the government are for the most part inapplicable where mutuality is present, as in *Stauffer Chemical, Montana* [footnote omitted] and *Moser*. The application of an estoppel when the government is litigating the same issue with the same party avoids the problem of freezing the development of the law because the government is still free to litigate that issue in the future with some other party. And, where the parties are the same, estopping the government spares a party that has already

> prevailed once from having to relitigate – a function it would not serve in the present circumstances [which involved nonmutual collateral estoppel].

United States v. Mendoza, supra, 464 U.S. at 163-64.[1]

2. The Importance of the Collateral Estoppel Issue

As discussed above, this is not the first Medicare case involving the question of whether collateral estoppel applies to wholly owned subsidiaries of a Medicare home office. Indeed, the issue has occurred several times in the past. *See,* cases cited previously and *American Medical International, Inc. v. Secretary of HEW,* 677 F.2d 118 (D.C. Cir. 1981), in which the Court of Appeals for the District of Columbia Circuit used reasoning similar to that used by the Ninth Circuit to allow the Secretary to relitigate the corporate maintenance issue against another hospital company after the hospital company had successfully litigated the very same issue against the Secretary before

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[1] Lest there be any question as to whether collateral estoppel is being urged offensively or defensively in this case, it is important to note that the Secretary is always the defendant in Medicare reimbursement cases since he always has the last word at the administrative appeal level. In this case, NME attempted to use collateral estoppel to defend itself at the administrative hearing level before the PRRB. However, the Secretary refused to abide by the doctrine and reversed the PRRB's favorable decision for the 1974-1979 fiscal years notwithstanding the final Claims Court decision for the 1973 fiscal year. NME was therefore forced to assume the offensive in this case. The distinction between the use of offensive and defensive collateral estoppel is therefore largely meaningless under the circumstances of this case.

the United States Court of Claims. And, because, providers are required to pursue the same issue for each and every affected cost year (*see Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 137-39 (9th Cir. 1980)), the issue will be a recurring one in Medicare.

Moreover, the mutuality issue in the context of government litigation is not confined to the Medicare field. For example, the question of whether nonparties to one lawsuit may bind the government from relitigating the same issue in a second lawsuit is a continuing one in the field of taxation. *See, e.g., Starker v. United States*, 602 F.2d 1341, 1344 (9th Cir. 1979).

The Court has granted certiorari previously to address the issue of whether the federal government may be collaterally estopped from relitigating issues against a private party. *See United States v. Mendoza, supra; United States v. Stauffer Chemical Co.*, 464 U.S. 165 (1984); and *Montana v. United States, supra.* Although the Court has disapproved of collateral estoppel against the government in the absence of mutuality, its concerns underlying the disapproval of collateral estoppel "are for the most part inapplicable where mutuality is present." *See United States v. Mendoza, supra*, 464 U.S. at 163-64.

The Court is respectfully requested to grant certiorari in this case to provide further guidance to the lower courts concerning the application of collateral estoppel against the government when mutuality is, in fact, present, as is the case here. The need for further guidelines in the area has been stressed by legal commentators. *See* Frossard, *Collateral Estoppel of the Government: Striking the Balance Between the Interests of the Government, the Private*

Litigant and Those Similarly Situated, 29 South Texas Law Review 385 (1987).

B. The Corporate Maintenance Costs Issue

1. The Ninth Circuit's Opinion is in Direct Conflict With the Opinion of the United States Court of Claims (Now the Court of Appeals for the Federal Circuit).

It is undisputed that as a publicly owned corporation, NME was required to incur the corporate maintenance costs in question. For example, NME was required by law to hold annual meetings of shareholders, to elect directors of the corporation, and to send annual reports to shareholders. Moreover, federal securities law required NME to incur a variety of accounting, legal, printing and other fees in order to meet the requirements of the Securities and Exchange Commission. The Secretary has never disputed these facts but rather argues that even though the costs are legally mandated they were incurred solely for the benefit of investors rather than for the "primary purpose" of benefiting patients. This "primary purpose test," like the Secretary's corporate maintenance policy itself, is nowhere set forth in the Secretary's regulations. The standard has been developed by the Secretary solely to defend his corporate maintenance costs policy from challenges in court.

The issue of whether the Secretary must reimburse a provider of health care services for its corporate maintenance costs has now been addressed by four Courts of Appeals – the Ninth Circuit in this case, the D.C. Circuit in *American Medical International, Inc. v. Secretary of Health,*

etc., supra, and in *Humana, Inc. v. Heckler*, 758 F.2d 696 (D.C. Cir. 1985), *cert. denied*, 474 U.S. 1055 (1986), the Fifth Circuit in *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir.) *cert. denied*, 469 U.S. 823 (1984), and the United States Court of Claims (now the Court of Appeals for the Federal Circuit) in *AMI-Chanco v. United States, supra*. In this case, the Ninth Circuit sided with the Court of Appeals for the D.C. Circuit and the Fifth Circuit and upheld the Secretary's policy while the District Court (and the PRRB) sided with the United States Court of Claims and invalidated the Secretary's policy.

There are at least two compelling reasons why corporate maintenance costs must be allowed under the Medicare statutes and regulations. First, the very same set of guidelines used by the Secretary to disallow corporate maintenance costs allow the identical kinds of costs, *i.e.*, shareholder meeting costs and legal fees, incurred to organize a corporate provider. *Compare* PRM-I Section 2134.1A with PRM-I Section 2134.9, Appendix at 76, 78. The United States Court of Claims in *AMI-Chanco* held that there was no rational basis for treating the costs of creating a corporate entity as allowable, indirect expenses of patient care while disallowing corporate maintenance costs that are essential to the ongoing maintenance of the corporate organization. *See* 576 F.2d at 324. The Ninth Circuit, the D.C. Circuit and the Fifth Circuit simply *ignored* this compelling fact.

The PRRB, a panel of reimbursement experts, held:

> The Board finds it perplexing that the Medicare program would encourage the creation of corporate entities to bring medical facilities into

> existence, and then deny the costs of maintaining the entities once such facilities are in existence. If the corporate entities are unable to maintain their existence, the medical facilities would also cease to exist. Such contradictory policy is not consistent with the intent of the Medicare program.

Appendix at 44.

The second compelling reason for requiring reimbursement for corporate maintenance costs, the one relied on by the District Court, is that the Secretary recognizes and allows as necessary and proper, as related to patient care, and as benefiting primarily patients, *debt* financing costs incurred by for-profit and nonprofit home offices and providers. *See* 42 C.F.R § 405.419 [1985] and PRM-I § 212.1. Corporate maintenance costs are necessarily related to the borrowing ability of a provider. For example, equity capital raised through the issuance of stock enables hospitals to borrow at preferential rates, thus reducing the amount of Medicare reimbursement owing for interest costs. District Court's Findings of Facts and Conclusions of Law, ¶ 19, Appendix at 21.

Corporate costs incurred in connection with equity financing are indistinguishable from similar costs incurred by providers in connection with debt financing, such as underwriting costs. The Secretary has provided no rationale for distinguishing such costs incurred in connection with equity financing from similar costs incurred with respect to debt financing. *See* District Court's Findings of Fact and Conclusions of Law, ¶ 19, Appendix at 21.

The Ninth Circuit attempted to justify the Secretary's reimbursement distinction between debt financing costs and equity financing costs on the grounds that the former are related to patient care while the latter are not. Appendix at 13. So long as the proceeds from either form of financing are used for the provision of patient care, both kinds of financing costs must be deemed to be related to patient care and to be reasonable and necessary under the statute and the Secretary's regulations. In short, Medicare patients are benefited whether a hospital's facilities and equipment were financed by debt or by equity. And, it should make no difference that shareholders (in the case of equity financing) rather than bondholders (in the case of debt financing) are compensated for the money they furnish the providers.

The Ninth Circuit simply gave too much deference to the Secretary's corporate maintenance costs policy. The policy is contained in the Secretary's guidelines, PRM-I, not in the formal Medicare regulations. This Court has held that the Secretary's informal manuals do not have the legal force and effect of agency regulations. *See Schweiker v. Hansen*, 450 U.S. 785, 789 (1981). Moreover, the Courts of Appeals, including the Ninth Circuit, have recognized that the provisions of the Secretary's Provider Reimbursement Manual are entitled to no particular deference. *See National Medical Enterprises, Inc. v. Bowen*, 851 F.2d 291, 293 (1988). Yet, in this case, for no good reason the Ninth Circuit gave substantial deference to the manual provisions. Appendix at 10-11.

Moreover, the Secretary's interpretation was not issued contemporaneously with the enactment of the Medicare statutes and regulations which it purports to

interpret and is not of long standing. Indeed, the 1973 PRM-I guidelines were applied to NME's 1973 fiscal year after NME had already begun providing the Medicare services for which reimbursement for the corporate maintenance costs was claimed.

Finally, there is anything but a consensus of expert opinion regarding the validity of the Secretary's corporate maintenance costs policy. Of particular note is the opinion of the PRRB, a panel of Medicare reimbursement experts, which held in favor of NME, but is not even mentioned in the Ninth Circuit opinion. Similarly, although generally accepted accounting principles and the practices and principles of other government regulators may not determine Medicare reimbursement, the lack of consistency of the Secretary's policy with such analogous principles, practices and policies is reason to avoid affording the policy any special deference. *See, e.g., Pacific Coast Medical Enterprises v. Harris, supra,* 633 F.2d at 132.

2. The Importance of the Corporate Maintenance Costs Issue

The Secretary's interpretation of the Medicare statute and regulations governing reasonable cost reimbursement continues to be of major significance to the health care industry, patients and taxpayers. A substantial body of case law has developed in the Court of Appeals with respect to issues of Medicare reimbursement under the reasonable cost system.[2] Indeed, the corporate

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[2] This is especially so with respect to the Secretary's PRM-I provisions. *See, e.g., National Medical Enterprises, Inc. v. Bowen,*

(Continued on following page)

maintenance cost issue, itself, has generated considerable controversy and has resulted in a split among the circuits.

Because, as here, the Secretary continues to establish policy through the Provider Reimbursement Manual, questions regarding the appropriate degree of judicial deference to the Secretary's policy arise constantly. Thus, ironically the very same Court of Appeals has held in another case involving NME (*National Medical Enterprises, Inc. v. Bowen, supra*) that the policy contained in the Secretary's Provider Reimbursement Manual is entitled to no special deference while it has held in this case that such policy is entitled to substantial deference.

The Medicare reasonable cost principles are of continuing importance to various kinds of providers in addition to hospitals, including skilled nursing facilities. Moreover, notwithstanding the transition from the reasonable cost system to the Medicare prospective payment system for medical/surgical hospitals (*see* 42 U.S.C. § 1395ww(d)), many kinds of hospitals, such as psychiatric hospitals, children's hospitals, and rehabilitation hospitals, continue to be reimbursed under the reasonable cost system. *See* 42 C.F.R. § 412.22 [1989] and 42

(Continued from previous page)

supra; *Vista Hill Foundation, Inc. v. Heckler*, 767 F.2d 556 (9th Cir. 1985); *Charlotte Memorial Hospital v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *St. Mary Hospital Center v. Schweiker*, 718 F.2d 459 (D.C. Cir. 1983); *Annie M. Warner Hospital v. Harris*, 639 F.2d 961 (3rd Cir. 1981); *Columbus Community Hospital v. Califano*, 614 F.2d 181 (8th Cir. 1980).

C.F.R. § 413.1 [1989]. Additionally, all hospitals' capital-related costs continue to be reimbursed under the reasonable cost system. *see* 42 C.F.R. § 413.130 [1989].

Additionally, numerous state Medicaid programs, including, for example, California's Medi-Cal program (*see* 22 California Code of Regulations Section 51536) continue to incorporate Medicare reasonable cost reimbursement principles into the methodologies used to determine payment rates to hospitals and other providers under the Medicaid program.

Finally, the PRRB continues to confront Medicare reasonable cost reimbursement issues, including the corporate maintenance costs issue, for hospitals and skilled nursing facilities. Recently, the PRRB again invalidated the Secretary's corporate maintenance costs policy. *See* PRRB Dec. No. 90-D43, Medicare and Medicaid Guide (CCH) ¶ 38,855.

CONCLUSION

The Court of Appeals has erroneously decided two critical issues – the first pertaining to the application of collateral estoppel against the federal government, and the second involving an interpretation of the Medicare statutes and regulations which continues to be important to the administration of the Medicare (and Medicaid) program. The Court is respectfully requested to grant the petition for a writ of certiorari to provide the appropriate

guidance to the lower courts on one or both of these important questions of law.

DATED: February 14, 1991.

Respectfully submitted,

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Attorney for Petitioner
National Medical Enterprises, Inc.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NATIONAL MEDICAL ENTERPRISES, INC., Doing Business Through Various Wholly-Owned Hospital Subsidiaries, *Plaintiff-Appellee,* v. LOUIS W. SULLIVAN M.D., Secretary of Health and Human Services, *Defendant-Appellant.*	No. 89-55859 D.C. No. CV-89-0072-JSL OPINION

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding

Argued and Submitted
April 10, 1990 – Pasadena,-California

Filed October 10, 1990

Before: Dorothy W. Nelson, William A. Norris and Diarmuid F. O'Scannlain, Circuit Judges.

Opinion by Judge Norris

SUMMARY

Medicare

Reversing a district court judgment, the court of appeals held that DHHS' regulation prohibiting health

providers Medicare reimbursement for stock maintenance costs incurred by their corporate owners had a rational basis and was, therefore, valid.

Eighteen hospitals sought Medicare reimbursement for stock maintenance costs incurred by their corporate owner, National Medical Enterprises, DHHS enacted a regulation that prohibited the reimbursement of expenses for stock maintenance costs. A district court invalidated DHHS' regulation, holding that it had no rational basis for denying the subsidiaries reimbursement. The court granted summary judgment for National Medical Enterprises. In a previous action, National and three of the subsidiary hospitals sought reimbursement for National's stock maintenance costs. The Claims Court held that DHHS improperly denied reimbursement because stock maintenance costs were reasonable expenses related to patient care. DHHS did not appeal this decision.

[1] Before addressing the merits of this action, the court considered National's claim of whether DHHS was collaterally estopped from relitigating the stock maintenance cost issue because National or its privies successfully litigated the issue in the previous Claims Court action. The court concluded that because mutuality did not exist, National could not use the defense of collateral estoppel. **[2]** The court did not need to decide whether and under what circumstances a parent corporation may seek judicial review under the Medicare Act. Because this lawsuit was grounded on the claims of eighteen wholly owned subsidiaries, fifteen of which were not involved in the prior action, the court concluded that mutuality was lacking, whether or not National was considered a proper

plaintiff. [3] Collateral estoppel would also be inappropriate where, as here, it would be unfair to DHHS. [4] On the merits, the court held that DHHS' decision to deny reimbursement for stock maintenance costs rested on a rational basis. DHHS was authorized to deny the subsidiaries reimbursement where such costs were not reasonably related to patient care or were unnecessary in the efficient delivery of needed health services. On review, the court did not find DHHS' decision to be arbitrary or capricious. [5] Although stock maintenance programs may influence the corporate form they had little bearing on the provision of patient services. [6] Stock maintenance programs are directed primarily at present and future stockholders, rather than at the provision or improvement of patient services. [7] The court rejected the argument that because hospital service providers are required by state and federal law to incur stock maintenance costs, such costs are necessary and proper costs within the meaning of the regulation in question. Medicare reimburses only those business expenses reasonably related to patient care. [8] The court also rejected National's claim that because Medicare reimburses debt financing costs, it was illegitimate for DHHS to deny reimbursement for stock maintenance costs. Interest and other borrowing costs are reimbursed under Medicare only when the loan is necessary and has a purpose reasonably related to patient care. [9] Because of these and other principles and precedents supporting DHHS' decision, the court found the district court judgment invalid. [10] The court summarily rejected National's contention that the regulations implementing the Medicare Act were

invalid because they were not established under APA's rulemaking procedure.

COUNSEL

Anthony J. Steinmeyer, Department of Justice, Civil Division, Washington, D.C., for the defendant-appellant.

Patric Hooper, Hooper, Lundy & Bookman, Inc., Los Angeles, California, for the plaintiff-appellee.

OPINION

NORRIS, Circuit Judge:

This case involves the claims of eighteen hospitals ("Providers") seeking Medicare reimbursement for stock maintenance costs incurred by their corporate owner, National Medical Enterprises ("NME"), during the fiscal years 1974 to 1979. The costs in dispute include stock transfer agent fees, stock and exchange registration fees and costs attributable to SEC filings, stockholder meetings, annual reports to stockholders, and institutional public relations related to stock and financial matters. The Secretary of Health and Human Services ("Secretary") ruled that, pursuant to the Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., known as the "Medicare Act", and internal agency regulations, stock maintenance costs were not reimbursable expenses. NME sought judicial review of the Secretary's decision in the United States District Court for the Central District of

California on behalf of its eighteen wholly-owned subsidiaries. After considering cross motions for summary judgment, the court ruled that the Secretary had no rational basis for denying the subsidiaries reimbursement and granted summary judgment for plaintiff-appellee. The Secretary timely appeals the district court's decision. We reverse.

I

Under the Medicare Act, providers are entitled to reimbursement for reasonable costs "necessary in the efficient delivery of needed health services" to Medicare patients. 42 U.S.C. § 1395x(v)(1)(A) (1988). Agency regulations established to implement the statutory mandate stipulate that the costs must be "necessary and proper," 42 C.F.R. § 405.451(b) (1985) (redesignated as 42 C.F.R. § 413.9(b) and "directly or indirectly related to patient care." 42 C.F.R. § 405.451(c) (1985) (redesignated as 42 C.F.R. § 413.9(c)).

In a previous action, NME and three of its subsidiary hospitals sought reimbursement for NME's stock maintenance costs during fiscal 1973. The Claims Court held that the Secretary had improperly denied reimbursement because, it said, stock maintenance costs were reasonable expenses related to patient care. *See National Medical Enterprises, Inc. v. United States ("NME")*, 11 Cl. Ct. 329 (1986). The Secretary did not appeal.

In the present action, NME, on behalf of the three subsidiaries involved in the Claims Court judgment and fifteen additional subsidiaries, claimed reimbursement for stock maintenance costs incurred by NME from fiscal

1974 to 1979. After an agency review process, the Secretary held that stock maintenance costs were incurred primarily for the benefit of present and future stockholders, not Medicare patients, and thus were not "reasonable costs" related to patient care under the Medicare Act. The Secretary also found that denial of reimbursement was consistent with the agency's Provider Reimbursement Manual ("PRM") §§ 2150.2B, 2134.9[1] interpreting the Act. According to the manual:

> The following types of costs relevant to the proprietary and equity interest of the stock holders, but not related to patient care, are excluded from allowable costs: Costs incurred primarily for the benefit of stockholders or other investors, including but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stock broker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

PRM § 2134.9.

The district court granted summary judgment for NME on the ground that the Secretary's decision lacked a rational basis. Stock maintenance costs, the court concluded, were necessarily incurred in securing equity financing for the provision of patient services. Moreover, the court found that stock maintenance costs were indistinguishable from other costs, such as debt financing, that

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[1] The Secretary issued an interpretation of the Act in January 1973, *see* PRM § 2150.2B, and August 1973, *see* PRM § 2134.9. Both provisions exclude stockholders servicing costs from reimbursement under the Act.

were reimbursed. Accordingly, the district court ruled that the Secretary's disallowance of stock maintenance costs had no rational basis. Because we conclude, on the contrary, that the Secretary's decision does rest on a rational basis, we reverse the district court's judgment.

II

[1] Before addressing the merits of this action, we consider NME's claim that the Secretary is collaterally estopped from relitigating the stock maintenance cost issue because NME or its privies already successfully litigated the issue in the previous Claims Court action. *See NME*, 11 Cl. Ct. at 329. Neither party disputes the well-established rule that nonmutual offensive collateral estoppel[2] cannot be asserted against the government. *See United States v. Mendoza*, 464 U.S. 154, 159-60 (1984). At issue, only, is whether mutuality exists, allowing NME the use of collateral estoppel. We hold that it does not.

The Secretary claims that mutuality is lacking because, although NME was the primary plaintiff in the Claims Court action, it is not the proper plaintiff in the case at bar. *See* Appellant's Reply Brief at 3-12. The Secretary points to 42 U.S.C. § 1395oo(f)(1), which stipulates that only "providers" of patient services may seek

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[2] "Offensive" collateral estoppel refers to the situation where a plaintiff seeks to foreclose a defendant from relitigating an issue the defendant has previously litigated unsuccessfully in another action against the same or a different party. *See Parklane Hosiery Co., Inc. v. Shore*, 439 U.S. 322, 326 n.4 (1979).

judicial review of agency decisions.[3] Drawing on a statutory definition of "provider" in 42 U.S.C. § 1395x(u)[4], the Secretary argues that NME, as the parent corporation, lacks standing to sue. *See* Appellant's Reply Brief at 3-12. NME counters that as the owner and home office of the subsidiaries, it is the appropriate party and contends that hospital owners "routinely" are named as plaintiffs in Medicare reimbursement suits. *See* Appellee's Brief at 15 n.3; Appellee's Reply Brief at 1-5.

[2] We need not decide whether, and under what circumstances, a parent corporation may seek judicial review under the Medicare Act. Because this lawsuit is grounded on the claims of eighteen-wholly owned subsidiaries – fifteen of which were not involved in the prior action – we conclude that mutuality is lacking, whether or not NME is considered a proper plaintiff. The facts of this case are that the eighteen providers, not NME, are the primary plaintiffs in this dispute. As wholly-owned subsidiaries, these providers contract with the Secretary to provide patient services, receive regular payment and submit annual cost reports showing the expenses

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[3] This section provides, in relevant part: "Providers shall have the right to obtain judicial review of any final decision by the Board, or of any reversal . . . by the Secretary by a civil action commenced within 60 days . . . . " 42 U.S.C. § 1395oo(f)(1) (1988).

[4] The section states that "[t]he term 'provider of services' means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, . . . a fund."

incurred during the fiscal year and the appropriate portion of those costs to be allocated to the Medicare program. Allowing a home office to establish mutuality merely by holding itself out as the "representative" of multiple subsidiaries would open the door for home offices with providers in multiple states to secure a favorable judgment in one circuit, then bind the government to that judgment in other circuits. Such a result would effectively freeze the law among circuits – a result explicitly disfavored by the Supreme Court in *Mendoza*, 464 U.S. at 160 (noting that nonmutual collateral estoppel against the government "would substantially thwart the development of important questions of law by freezing the first final decision rendered on a particular legal issue."). *See also American Medical Int'l, Inc. v. Secretary of HEW ("AMI")*, 677 F.2d 118, 124 (D.C. Cir. 1981) (holding that subsidiary providers that were not parties to a previous Medicare reimbursement suit could not use collateral estoppel against the government).

[3] We also reject NME's contention that even if the parties in the disputed actions were different, collateral estoppel is still appropriate because NME and the fifteen subsidiaries that were not involved in the Claims Court action were in privity with each other. Whatever relationship exists between NME and its offspring is not sufficient to override the important values limiting the use of collateral estoppel. As courts have long recognized, collateral estoppel is inappropriate where, as here, it would be "unfair" to the defendant, *Parklane Hosiery Co., Inc. v. Shore*, 439 U.S. 322, 331 (1979), or where "applying preclusion [would] give one person a favored position in current administration of the law," *AMI*, 677 F.2d at 124

(quoting Restatement (Second) of Judgments § 68.1 at 33 (Tent. Draft No. 4, 1977)). Courts of appeals consistently have denied providers Medicare reimbursement for stock maintenance costs. *See AMI*, 677 F.2d at 124; *Humana, Inc. v. Heckler*, 758 F.2d 696, 700 (D.C. Cir. 1985), *cert. denied*, 474 U.S. 1055 (1986); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 327 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984). In addition to creating inconsistency among the circuits, allowing the subsidiaries in the present case to be reimbursed would unduly privilege them vis-a-vis providers in similar circumstances. We see no reason to countenance such disparity. We therefore deny NME the benefit of collateral estoppel.

III

[4] Turning to the merits of the case, we hold that the Secretary's decision to deny reimbursement for stock maintenance costs rested on a rational basis. Pursuant to Congressional directives, the Secretary is entitled to deny the subsidiaries reimbursement where such costs are not "reasonably related to patient care" or are "unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A) (1988). Judicial deference to an agency determination is particularly important where, as here, Congress has vested broad discretion in an agency to interpret a statute, *see AMI*, 466 F. Supp. 605, 611 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981), and the implementing regulations are highly complex, *see Bedford Medical Center v. Heckler*, 766 F.2d 321, 323 (7th Cir. 1985) ("the interpretations of regulations issued pursuant to a statute, especially a statute as complex as the Medicare Act, are entitled to considerable deference."). On review,

we may not overturn the Secretary's decision unless it is "arbitrary, capricious, an abuse of discretion, or not otherwise in accordance with law." Administrative Procedure Act ("APA"), 5 U.S.C. § 706(2)(A) (1988); *see also* 42 U.S.C. § 1395oo(f)(1) (1988) (explicitly incorporating the APA's standard of review into the Medicare Act). On these terms, we can find no basis for overturning the Secretary's decision.

[5] Although stock maintenance programs may influence the corporate form, they have little bearing on its substance, the provision of patient services. *See, e.g., Humana, Inc.*, 758 F.2d at 700 (finding stock maintenance costs unnecessary for the provision of patient services); *Sun Towers, Inc.*, 725 F.2d at 327 (same); *AMI*, 466 F. Supp. at 613 (stating that although "[s]tock maintenance costs are necessary for a corporation to exist . . . medical service can be provided without the corporate form").

[6] As other circuits have recognized, stock maintenance programs are directed primarily at present and future stockholders, rather than at the provision or improvement of patient services. As the Secretary points out, costs associated with SEC filings provide prospective or current shareholders with a corporation's financial condition before they purchase, sell or retain their stock. Likewise, stockholders meetings and reports inform such shareholders about a corporation's financial condition. Although such programs are essential to shareholders, their "relationship to the provision of health care is too remote to allow them to be considered reasonable costs necessary to providing that care." *AMI*, 466 F. Supp. at 613 (footnote omitted). Under these conditions, it was

reasonable for the Secretary to deny the subsidiaries reimbursement.

[7] We reject NME's claim that because hospital service providers are required by state and federal law to incur stock maintenance costs, such costs are "necessary and proper" costs within the meaning of 42 C.F.R. § 405.451. As the *Sun Towers* court noted, "even necessary business expenses must also be necessary to patient care in order to be reimbursed under Medicare." 725 F.2d at 328. It is irrelevant that the Internal Revenue Service or other federal agencies treat stock maintenance costs as reimbursable business expenses. Medicare reimburses only those business expenses reasonably related to patient care.

Nor is it probative, as NME contends, that generally accepted accounting principles include stock maintenance costs in a corporate provider's allowable general and administrative costs. Such procedures promote uniform recordkeeping; they do not proscribe reimbursable costs. *See AMI*, 466 F. Supp. at 623-24 (noting that the "regulation is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs.").

Moreover, as our circuit has noted, when generally accepted accounting practices "do not accurately reflect the cost of patient care, as opposed to the cost of running a business, the Secretary reserves the right to prescribe different accounting practices." *North Clackamas Community Hospital v. Harris*, 664 F.2d 701, 706 n.16 (9th Cir.

1980). Such principles support the Secretary's denial decision.

[8] We also reject NME's claim that because Medicare reimburses debt financing costs, it is illegitimate for the Secretary to deny reimbursement for stock maintenance costs. Stock maintenance costs, NME argues, are simply an aspect of equity financing, indistinguishable from underwriting and other debt financing costs that are reimbursed. Although the district court grounded its opinion on this apparent inconsistency, we find such an argument unpersuasive. Interest and other borrowing costs are reimbursed under Medicare only when the loan is necessary and has a "purpose reasonably related to patient care." 42 C.F.R. § 405.419(b)(2) (ii) (1985) (redesignated as 42 C.F.R. § 413.153). As indicated previously, stock maintenance costs do not meet these criteria.

We likewise find invalid NME's claim that the Secretary's denial conflicts with a Medicare policy of attracting investment capital for purposes of encouraging corporate providers of Medicare services. Under 42 U.S.C. § 1395x(v)(1)(B), providers may receive a return-on-equity investment, a lump sum payment for the use of private capital in health care facilities. Although Congress could have allowed reimbursement for other expenses, it chose not to do so. As the district court in *AMI* noted, "[i]t is clear from the purpose behind the return on equity provision . . . , its legislative history, and the provision itself that the return on equity capital provision cannot be used by plaintiffs to support the position that reasonable costs . . . was meant to include costs for investment." 466 F. Supp. at 613.

Indeed, that Congress, in its numerous amendments to the Medicare Act, has never taken an action that conflicts with the agency's position may be seen as "persuasive evidence" that it does not object to the government's interpretation of the Act. *FDIC v. Philadelphia Gear Corp.*, 476 U.S. 426, 437 (1986). Other courts consistently have respected the agency's Medicare reimbursement limits. *See AMI*, 466 F. Supp. at 613-14; *Sun Towers*, 725 F.2d at 329 n.26.

Finally, we reject NME's claim that it is inconsistent for the agency to reimburse costs of meetings and annual reports for non-profit providers, while denying them for for-profit providers. Although the Medicare Act mandates that the Secretary treat for-profit and not-for-profit organizations equitably, *see* 42 C.F.R. § 413.5(b)(5) (1989), distinctions are permissible so long as they have a rational basis. *See Hospital Authority of Floyd County, Ga. v. Schweiker*, 522 F. Supp. 569, 575-76 (N.D. Ga. 1981), *aff'd*, 707 F.2d 456 (11th Cir. 1983); *AMI*, 466 F. Supp. at 615. Differing treatment in the case at bar clearly is supportable. For-profit organizations primarily hold meetings and issue reports to aid shareholders and to attract investment that will increase returns. Non-profit organizations, by contrast, generally have no such financial motivation. To the contrary, as the *AMI* and *Sun Towers* courts recognized, their efforts primarily are aimed at providing improved medical care. *See Sun Towers*, 725 F.2d at 328; *AMI* 466 F. Supp. at 615. It is thus reasonable for the agency to compensate only those expenses that are closely tied to the provision of patient services.

[9] Because of the strong principles and precedents supporting the Secretary's decision, we find the district

court's judgment invalid and hold that the Secretary's denial of stock maintenance costs rested on a rational basis.

IV

[10] We summarily reject NME's contention that the regulations implementing the Medicare Act, *see* PRM §§ 2150.2B, 2134.9, are invalid because they were not established pursuant to the rule-making procedures of the APA. Under 5 U.S.C. §§ 553(b)(A), the APA excludes from its procedures "interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice." The agency manual through which the Secretary excluded stock maintenance costs merely clarified those expenses necessary for or related to patient care. As such, it was exempt from APA requirements.

The judgment of the district court is REVERSED.

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

NATIONAL MEDICAL ENTERPRISES, INC., a Nevada corporation, doing business through various wholly-owned hospital subsidiaries, Plaintiff, v. OTIS BOWEN, M.D., Secretary of the Department of Health and Human Services, Defendant.	No. SA CV 89-0072 JSL FINDINGS OF FACT AND CONCLUSIONS OF LAW (Filed June 14, 1989)

FINDINGS OF FACT

1. Plaintiff, National Medical Enterprises, Inc. ("NME"), is the Medicare "home office" for the hospitals involved in this case. (Complaint and Answer, para. 4.)

2. Defendant, Otis Bowen, M.D., was the Secretary of the Department of Health and Human Services ("Secretary") when the decision under review was issued. The Secretary is the federal official responsible for administering the Medicare program. The day-by-day administration of the Medicare program has been delegated by the

Secretary to the Health Care Financing Administration ("HCFA"). (Complaint and Answer, para. 5.)

3. The Medicare Act establishes a system of health insurance for the aged and disabled. 42 U.S.C. § 1395 et seq. Each hospital in question entered into a written agreement with the Secretary to provide hospital services to eligible individuals as a "provider of services" ("Provider") under the Medicare Act. 42 U.S.C. § 1395cc. Each hospital in question at all relevant times was, and now is, eligible for payment for such services, and is entitled to be reimbursed for the reasonable cost of rendering hospital services to Medicare beneficiaries. 42 U.S.C. § 1395f(b). (Complaint and Answer, para. 6.)

4. Payments to providers are carried out by fiscal intermediaries pursuant to contract with the Secretary. Fiscal intermediaries make interim payments to providers, subject to subsequent adjustments for overpayments or underpayments. 42 U.S.C. § 1395h. (Complaint and Answer, para. 7.)

5. At the close of its fiscal year, a provider must submit a "cost report" showing both the costs incurred by it during the fiscal year and the appropriate portion of those costs to be allocated to the Medicare program. 42 U.S.C. §§ 405.406(b) [1985] and 405.453(f) [1985]. The fiscal intermediaries are required to analyze and audit the costs report and to inform the provider of a final determination of Medicare reimbursement. 42 C.F.R. § 405.1803 [1985]. (Complaint and Answer, para. 8.)

6. If a provider is dissatisfied with its fiscal intermediary's final determination of total program reimbursement for a cost reporting period and if it meets

the requirements set forth in 42 U.S.C. Section 1395oo(a), it may appeal the intermediary's decision to the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo. The decision of the PRRB becomes final unless the Secretary, through HCFA, reverses, affirms, or modifies the PRRB's decision. 42 U.S.C. § 1395oo(f). (Complaint and Answer, para. 9.)

7. Providers have the right to judicial review of any final decision of the PRRB, or of any reversal, affirmance, or modification by the Secretary, by means of a civil action filed in the United States District Court for the judicial district in which the provider is located, and the United States District Court for the District of Columbia or, for an action brought jointly by several providers, as is the case here, the judicial district in which the greatest number of providers are located. 42 U.S.C. § 1395oo(f). (Complaint and Answer, para. 10.)

8. For hospital fiscal years ending prior to October 1, 1983, the Medicare Act requires that providers be reimbursed for services furnished to Medicare beneficiaries on the basis of the "reasonable costs" of such services. 42 U.S.C. § 1395x(v)(1)(A). Reasonable cost is defined as "costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services." (Complaint and Answer, para. 11.)

9. In prescribing regulations to determine "reasonable" costs, the Secretary is directed by 42 U.S.C. Section 1395x(v)(1)(A) to take into account both the direct and the indirect costs of providers of services. Regulations have been issued by the Secretary to implement the reasonable

cost provisions of the Medicare Act. (Complaint and Answer, para. 12.)

10. NME is a publicly-traded corporation. During the fiscal periods in question, 1974 - 1979, as well as during previous fiscal years, including the 1973 fiscal year, NME incurred costs classified by Medicare as "stock maintenance costs," which include costs of annual reports to NME's stock holders, costs of annual meetings, stock transfer agent fees, stock and exchange registration fees, and the cost of filing reports with the Securities and Exchange Commission. The Secretary recognizes that home offices, such as NME, provide central management and administrative services to their member hospitals. Thus, those costs of a home office which are deemed to be allowable costs may be allocated to the home office's providers as part of their allowable, indirect costs of providing patient care. (Complaint and Answer, para. 13.)

11. The hospitals in question in this matter claimed allocable portions of the stock maintenance costs on their cost reports for the 1974 - 1979 fiscal periods. (Complaint and Answer, para. 14.)

12. NME's home office fiscal intermediary disallowed the claimed stock maintenance costs for the 1974 through 1979 fiscal years as well as for the 1973 fiscal year based on policy contained in Provider Reimbursement Manual Sections 2150.2B.1 and 2134.9.

13. With respect to the 1973 fiscal year, NME and three of its wholly-owned hospital subsidiaries requested an intermediary hearing pursuant to 42 C.F.R. Section 405.1811 [1985] to challenge the disallowance of the stock maintenance costs for the 1973 fiscal year. (For fiscal

years ending on or before June 30, 1973, Medicare reimbursement hearings were conducted by intermediary hearing officers rather than the PRRB.) The fiscal intermediary hearing officer upheld the disallowance of the claimed stock maintenance costs. (Complaint and Answer, para. 16.)

14. NME and its three wholly-owned hospital subsidiaries sought judicial review of the decision of the fiscal intermediary regarding the 1973 fiscal year before the United States Claims Court. On December 10, 1986, the Claims Court granted judgment in favor of NME and its wholly-owned subsidiaries with respect to their claim for reimbursement owed for the stock maintenance costs for the 1973 fiscal year. The Secretary did not appeal the United States Claims Court decision, which has now become final. (Complaint and Answer, para. 17.)

15. With respect to the disallowances of corporate maintenance costs for the 1974 – 1979 fiscal years, NME and its wholly-owned subsidiaries appealed to the PRRB. On July 21, 1988, the PRRB issued a decision in favor of NME reversing the audit disallowances made by the Medicare fiscal intermediary for the 1974 - 1979 fiscal years. (Complaint and Answer, para. 18.)

16. The HCFA Administrator subsequently decided to review the PRRB's decision. On August 31, 1988, the Deputy Administrator for HCFA issued a decision reversing the decision of the PRRB. (Complaint and Answer, para. 19.)

17. As a public corporation, NME was required by state and federal law to incur stock maintenance costs as part of its operating budget. NME was required to hold

annual meetings of shareholders to elect directors of the corporation, and to send annual reports to shareholders. Moreover, federal securities law required NME as a public corporation to incur various accounting, legal, printing and other fees in order to meet the requirements of the Securities and Exchange Act. (Ad. Rec. 257-258.)

18. Under generally accepted accounting principles, stock maintenance costs are deemed to be part of a corporate provider's general and administrative costs. (Ad. Rec. 254.)

19. Stock maintenance costs are necessarily related to the borrowing ability of a provider. For example, equity capital raised through the issuance of stock enables hospitals to borrow at preferential rates, thus reducing the amount of Medicare reimbursement owing for interest costs. (Ad. Rec. 267-268.) Stock maintenance costs incurred in connection with equity financing are indistinguishable from similar costs incurred by providers in connection with debt financing, such as underwriting costs. The Secretary has provided no rationale for distinguishing stock maintenance costs incurred in connection with equity financing from similar costs incurred with respect to debt financing. So long as the proceeds from either form of financing are used for the provision of patient care both kinds of financing costs must be deemed to be related to patient care. In this case, the stock maintenance costs were incurred in connection with equity financing used for the provision of patient care.

20. Other federal agencies, including the Internal Revenue Service, treat stock maintenance costs as ordinary and necessary business expenses which are part of a

corporation's general and administrative costs. (Ad. Rec. 254-256.)

[21. Proposed language deleted by court]

CONCLUSIONS OF LAW

22. This action arises under Title XVIII of the Social Security Act, as amended, 42 U.S.C. Section 1395 *et seq.*

23. Jurisdiction exists under 42 U.S.C. Section 1395oo(f).

24. Venue lies in this judicial district pursuant to 42 U.S.C. Section 1395oo(f) in that the greatest number of plaintiff's hospitals affected by the administrative decision in question are located within this judicial district.

25. Stock maintenance costs are necessarily incurred by providers in connection with equity financing. Such costs are indistinguishable from costs incurred by providers in connection with debt financings, such as underwriters costs, which are reimbursed by the Secretary. There is no rational basis for disallowing the costs incurred by providers in connection with equity financings while allowing similar costs of debt financings. Both kinds of financing costs are appropriate and helpful in maintaining the operation of patient care facilities and activities and are common and accepted costs in the health care industry. As a result, under the Medicare statute and regulations, stock maintenance costs must be allowed.

[26. Proposed language deleted by court]

27. Based on the foregoing, the Secretary's decision must be set aside and the decision of the PRRB must be affirmed. As a result, the Medicare fiscal intermediary's audit adjustments must be reversed for the fiscal periods at issue and NME and its wholly-owned subsidiaries must be reimbursed for the stock maintenance costs in question together with interest thereon in accordance with 42 U.S.C. Section 1395oo.

DATED: 6/14/89

/s/ Spencer Letts
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

NATIONAL MEDICAL ENTERPRISES, INC., a Nevada corporation, doing business through various wholly-owned hospital subsidiaries, Plaintiff, v. OTIS BOWEN, M.D., Secretary of the Department of Health and Human Services, Defendant.	No. SA CV 89-0072 JSL JUDGMENT (Filed June 14, 1989)

Plaintiff's Motion for Summary Judgment and Defendant's Cross-Motion for Summary Judgment having come on regularly for hearing before the Honorable J. Spencer Letts on May 1, 1989, and the Court having fully considered the written and oral arguments of the parties together with the other pleadings and documents on file in this case, including the administrative record, hereby concludes and orders that plaintiff's Motion for Summary Judgment and hereby is granted and defendant's Cross-Motion for Summary Judgment be and hereby is denied for the reasons set forth in the Court's Findings of Fact and Conclusions of Law. As a result, defendant's decision

must be set aside and plaintiff must be reimbursed for the stock maintenance costs in question, as indicated in the decision of the Provider Reimbursement Review Board, together with interest thereon pursuant to 42 U.S.C. Section 1395oo for the fiscal years in question; and plaintiff is entitled to its costs of suit.

DATED: 6-14-89

/s/ Spencer Letts
UNITED STATES
DISTRICT JUDGE

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

HEARING ON RECORD
88-D26

Provider – National Medical Enterprises, Inc. (NME)[1]	Date of Hearing- May 18, 1988
VS	Cost Reporting Period Years 1974-1979
Intermediary - Aetna Life Insurance Company[1]	Case No. 83-1000G

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ISSUE:

Whether stock maintenance costs incurred by the Providers and/or allocated to them by their home office are allowable costs under Medicare law and regulations?

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[1] See attached Schedule of Providers in Group

SUMMARY OF FACTS:

The Providers in this group appeal are general, acute care hospitals which are owned and operated by National Medical Enterprises, Inc. (NME) (See Attached Schedule of Providers in Group). For the cost reporting years in contention, the Providers claimed costs categorized by Medicare as stock maintenance costs which were disallowed by the Intermediaries as unnecessary expenses that were not related to patient care. Stock maintenance costs include such items as the costs associated with stockholder reports and meetings, stock transfer fees, legal and accounting fees relating to Securities and Exchange Commission (SEC) filings, and fees for various other required registrations or filings. The Providers took exception to the Intermediaries' adjustments, filed timely requests for hearing with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835 and 405.1837 and have met the jurisdiction requirements thereof. The aggregate effect of the adjustments on Medicare reimbursement is approximately $352,000.

Providers' Contentions:

NME contends that the Medicare law and regulations define allowable costs to include indirect costs which are incurred to provide services to patients. A summary of its reasons for the inclusion of stock maintenance costs as indirect patient care costs are as follows:

(1) Stock maintenance costs are ordinary and necessary business expenses, and a separate classification of such costs based on the

assertion that they are not related to patient care is arbitrary.

(2) Program regulations make no distinction between corporations and other forms of entities that operate hospitals. Moreover, since the Medicare program requires corporate providers to comply with laws relating to corporate status as a condition of participation, corporate maintenance costs should not be treated differently than equivalent costs for other forms of entities.

(3) It is arbitrary to disallow the costs at issue which are incurred to raise capital when all other costs of raising capital are allowed.

(4) Costs related to procuring equity capital produce lower borrowing costs and are also consistent with program policies which encourage the raising of capital through equity investment.

(5) Since similar costs are reimbursed to individual investor-owned providers and nonprofit providers, it is discriminatory to disallow them to publicly held investor-owned providers.

(6) Such costs are reimbursed by private third party payment organizations and other government reimbursement programs.

(7) Disallowance of such costs requires hospitals or non-program patients to bear such costs in violation of law.

(8) Such costs are incurred as part of borrowing requirements or as employee compensation under stock option plans and, thus, are allowable as either costs of borrowing or employee fringe benefits.

(9) The manual provisions which disallow stock maintenance costs were not validly

issued under the Administrative Procedure Act (APA). The disallowance of such costs is inconsistent with regulations which support their reimbursement.

Some of the major arguments offered by NME in support of its position are as follows:

A. The Classification of Certain Costs as "Corporate Stock Maintenance Costs" is an Arbitrary One, Since Such Costs are a Part of a Business' General and Administrative Costs.

The provisions of 42 CFR 405.406(a) require that costs be determined in a manner consistent with standard accounting definitions and reporting practices which are widely accepted in the hospital and related fields. The inclusion of stock maintenance costs as part of a corporation's general and administrative expense is a practice recognized by the accounting profession and other government agencies, and has also been recognized by the Board in various prior decisions. Relying upon this widely accepted standard that such costs are part of a corporation's general and administrative expense, the Court of Claims in *AMI – Chanco, Inc., v. U.S.*, U.S. Ct of Claims, 576 F2d 320, (1978) held that they are reimbursable pursuant to 42 CFR 405.406(a).

B. Stock Maintenance Costs are Necessarily Incurred in Maintaining NME and its Providers as Corporate Entities.

The provisions of 42 CFR 405.429(a)(2) and 405.603(b) expressly recognize corporate providers of services under

the Medicare program. Accordingly, the payment of indirect costs of providers would necessarily include business expenses relating to the corporate entity. Whereas the regulations contain no prohibition against reimbursement of corporate maintenance costs, the provisions of Section 2134.1A of HIM 15-1 specifically provide for the reimbursement of such corporate entity costs as legal and accounting fees, directors' fees and other organization costs required to create the corporate entity. While the costs of creating the corporation are considered necessary and proper in providing patient care, the costs of stockholders' meetings and reports and the costs of SEC filings which are required to legally maintain the entity are deemed not allowable.

By contrast, neither regulation nor manual provisions disallow nonprofit corporation costs of such meetings or reports. When such costs are incurred by nonprofit hospitals, they are paid by the Medicare program. Not only is there no logic to the distinction between investor-owned and nonprofit corporations, but the provisions of 42 CFR 405.402(b)(5) expressly prohibits discrimination in cost reimbursement principles applied to nonprofit and profit making organizations.

C. Stock Maintenance Costs are One of the Allowable Costs of Obtaining Capital

The Medicare program reimburses the costs of obtaining funds from almost all sources. This includes interest expense, management fees, consulting and accounting fees, appraiser fees, printing costs, advertising costs and similar costs of issuing debt securities such as bonds or

notes. These costs of financing are clearly included in the scope of necessary and proper costs under 42 CFR 405.451. Additionally, the costs incurred in seeking government or private grants, including funds from the Hill-Burton program which are available to public or non-profit hospitals, are allowed by the program. In addition to the costly application process, obtaining Hill-Burton funds also requires participation at hearings and the filing of various periodic progress reports with respect to the application of the construction funds.

Despite the fact that the costs of obtaining debt capital or grant capital are reimbursed in all instances, the costs incurred in connection with procuring equity capital are not allowed on the basis that they are too remote from patient care. Some of the cost items identified as stock maintenance, (e.g. costs incurred for filing SEC reports, stock transfer fees, stock exchange fees, etc.), are incurred to attract equity capital to investor-owned providers. The Medicare regulations are explicit in stating that it is program policy to attract investment capital to proprietary providers, that capital obtained through invested funds is entitled to earn a return, and that such a return is a cost of providing services to patients. The regulation at 42 CFR 405.429(b) recognizes that proprietary institutions finance capital expenditures through invested funds in the expectation of earning a return. The capital raised from public issuances could not have been raised without incurring costs to attract stockholders and to maintain the stockholders' records. Again, it is contradictory and arbitrary for the program to encourage the attraction of investment capital while disallowing the costs of doing so on the premise that they are not related to patient care.

D. Stock Maintenance Costs Permit Lower Borrowing Costs

NME has been able to obtain preferred borrowing rates as a direct result of the relationship of its equity capital to its total capital structure. As the proportion of equity to total capital increases, the company is assigned a higher credit rating which, in turn, permits lower borrowing costs. Without investment capital, borrowing costs would have exceeded the return paid by Medicare for equity capital.

E. Since the Program Allows Similar Costs of Individual Investor-Owned Facilities and of Voluntary Not-For-Profit Facilities, it is Discriminatory to Disallow Such Costs to NME Providers

The provisions of Section 2134.9 and 2150.2B of HIM 15-1 classify costs of the annual stockholders' meeting and the stockholders' report as stock maintenance costs. Many investor-owned hospitals which are neither part of chain organizations nor publicly held are required by law to hold annual meetings and are generally required to issue reports and financial statements to stockholders. NME notes that the costs associated with such requirements have never, to its knowledge, been disallowed by the program. Since voluntary not-for-profit hospitals also have annual meetings and prepare reports for their members, similar comparisons can be made for related costs incurred by such hospitals. Although it is the Medicare program's position that such costs incurred by voluntary organizations are not related to investors but to a community purpose, NME asserts that there is no reasonably

basis to allow the cost to one type of provider but not to the other.

F. Failure to Reimburse for Stock Maintenance Costs Illegally Shifts the Cost of Treating Medicare Patients to Non-Medicare Patients

The Medicare statute, 42 USC Section 1395x (v)(1)(A), requires that costs of treating Medicare patients not be shifted to non-Medicare patients. This requirement that Medicare bear its full share of providers' reasonable and actual costs is repeated throughout the Medicare regulations (42 CFR 405.402(a), 405.402(b)(3), 405.403(b), 405.451(b)(1) and 405.452(b)). Disallowance of stock maintenance costs by the Medicare program leaves no alternative but to collect these costs from non-Medicare patients.

G. Medicare Regulations Support Reimbursement of Stock Maintenance Costs/The Manual Provisions Dealing with Stock Maintenance Costs were not Validly Issued under the APA

While the Medicare regulations do not deal directly with stock maintenance costs, various regulatory provisions support reimbursement for such costs. In addition to the regulatory requirements previously mentioned, the general provisions of 42 CFR 405.402 and 405.451 recognized all necessary and proper costs of an institution in the production of services as being allowable. Prior to the 1973 issuance of Sections 2134.9 and 2150.2B of HIM 15-1 denying the reimbursement of these costs, no such rules previously existed. Given the significance and substance

of a rule governing stock maintenance or stockholder servicing costs, the law requires such rules to be issued only after giving them full consideration in the manner required by the APA. If the rules are not so enacted, they must be ignored.

H. Stock Maintenance Costs are not Reimbursed as Part of the Rate of Return on Equity Capital

In reversing prior Board decisions on this issue, the Administrator of the Health Care Financing Administration (HCFA) ruled that stock maintenance costs are disallowed because they are not related to the care of patients. The Administrator further claimed that these costs are somehow compensated as part of the rate of return paid on equity capital by the Medicare program. NME finds these contentions inherently inconsistent. If costs are in fact unrelated to patient care, they cannot be reimbursed under any formula without violating a basic precept of the Medicare Act.

Under 42 CFR 405.429(b), a rate of return on equity capital has been established at a level necessary to attract additional capital and prevent the withdrawal of existing capital. Since stock maintenance costs are fixed costs unrelated to market conditions, the inclusion of such costs in the rate of return would disrupt the return on equity provided by law, resulting in different market rates paid to different investor-owned providers. NME contends that, since studies have shown that the return is insufficient to accomplish the purpose of the regulations at the present rate, it can hardly be adequate to cover the costs in dispute in this case.

There is no legislative history, economic study or other documented basis showing how the rate was determined, much less to support a claim that the rate of return covers payment of stock maintenance costs. Since it is impossible to determine what items of costs, if any, were ever included within the rate, the assertion that the stock maintenance costs are to be paid from the investors' return is totally unsupported. Although there is no authority to support the assertion that the return on equity was intended to cover stock maintenance costs, Sections 2134.9 and 2150.2B of HIM 15-1 indicate that the Medicare program's policy is exactly to the contrary, i.e. they consider stock maintenance costs not related to the care of patients and, therefore, not reimbursable.

In *AMI-Chanco*, the Court of Claims rejected the inclusion of stock maintenance costs within the rate of return and held that absent any legislative history, a plain reading of the statute indicates that the payment of the return on equity capital is in lieu of other "similar" payments for the use of capital. The court concluded, therefore, that reimbursements for stock maintenance costs are not similar to payments for use of capital.

Based on the above, NME requests that the Board reverse the disallowance of the costs characterized as stock maintenance costs and hold that such costs are reasonable, necessary and related to patient care.

Intermediaries' Contentions:

The Intermediaries contend that the expenditures at issue were incurred for the purpose of furthering the financial interests of NME's stockholders and not for the benefit of

patients. They assert that health care can be rendered without the incurrence of stock maintenance costs, as demonstrated by not-for-profit organizations, partnerships and individual proprietorships. They further argue that shareholder service costs are precluded from program reimbursement by Section 1861(v)(1)(A) of Social Security Act as an expense not necessary for the efficient delivery of needed health services, and by 42 CFR 405.451 as costs not related to patient care.

In response to NME's contention that it is inconsistent for the program to reimburse for the use of capital but not the costs of maintaining this capital, the Intermediaries state that the only compensation allowed for the use of equity capital is contained in Section 1861(v)(1)(B) of the Act and 42 CFR 405.429. These provisions indicate that a reasonable return on equity capital is provided in lieu of other allowances to the extent that they reflect similar items. Since there is no provision for reimbursing the maintenance of equity capital, the Intermediaries conclude that they are not empowered to make additional reimbursement for that purpose.

The Intermediaries contend that they are unaware that not-for-profit and individual proprietary-owned facilities incur similar stock maintenance costs. With respect to individual owners, the Intermediaries note that the provisions of Section 902.2 of HIM 15-1 do not recognize as allowable cost the payment of compensation which is primarily for the purpose of managing or improving the owner's financial investment. Regarding the allowance of similar type costs incurred by non-profit organizations, the Intermediaries insist that the purpose of those activities and costs is fundamentally different from for-profit

corporations. Whereas the purpose of for-profit corporations is to enhance the return to their owners, a not-for-profit organization is prohibited by law from engaging in activities which would create profits to individuals operating the corporation. Although the regulation at 42 CFR 405.402(b)(5) requires equitable treatment of profit and non-profit organizations, it does not require identical treatment for both types. This is demonstrated by the fact that the program permits a return on capital for profit-making corporations but not for capital invested in non-profit organizations.

In rebuttal to the Providers' position that it is inconsistent for the Medicare program to reimburse the costs of issuing bonds and deny similar stock maintenance costs, the Intermediaries state that whereas bond expenses are specifically allowed by the manual, the provisions of Section 2134.9 of HIM 15-1 specifically disallow stock maintenance costs. The Intermediaries further note that 42 CFR 405.419 requires that the borrowed funds be incurred for providing medical care in order for such bond expenses to be reimbursable.

Another argument put forth on behalf of the Providers is that Section 2134.9 of HIM 15-1 is invalid because it was not issued in accordance with the APA. In response, the Intermediaries cite the ruling by the U.S. District Court for the District of Columbia, *American Medical International, Inc., et al. v. Secretary*, USDC (D. of C.), 466 F.Supp. 605 (1979), in which the Court ruled that manual Section 2134.9 was a valid interpretive rule because it was issued to advise the public of the agency's construction of the statute which it administers. Under 5 U.S.C. Section

553(b)(A) of the APA, interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice, are excluded from the requirement of notice and comment rulemaking.

In further support of their position, the Intermediaries note that the disallowance of stock maintenance costs has been upheld by the HCFA Administrator and U.S. Courts. Two cases cited are *American Medical International, Inc. v. Secretary*, CA (D. of C.), 677 F2d 118 (1981), and *Humana, Inc., et al. v. Heckler*, CA (D. of C.), 758 F2d 696 (1985), wherein the U.S. Court of Appeals, District of Columbia, upheld the decisions of the D.C. District Court and the HCFA Administrator concerning Board Decision Nos. 77-D61 and 81-D12, issued September 8, 1977 and February 5, 1981, respectively.

CITATIONS OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. *Law – Title XVIII of the Social Security Act*: Section 1861 (v)(1)(A) – Reasonable Costs

2. *Regulations – 42 CFR 405, Subpart D*:

   a. Section 405.402 – Cost Reimbursement: General

   b. Section 405.406 – Financial Data and Reports

   c. Section 405.429 – Return on Equity Capital of Proprietary Providers

   d. Section 405.451 – Cost Related to Patient Care

3. *Program Instructions – Provider Reimbursement Manual, Part I (HIM 15-1)*:

a.	Section 1200ff	– Return on Equity Capital of Proprietary Providers
b.	Section 2100ff	– Cost Related to Patient Care
c.	Section 2134ff	– Organization and Other Corporate Costs
d.	Section 2134.9	– Stockholder Servicing Costs
e.	Section 2150.2	– Home Office Costs – Chain Operations, Determination of Allowable Costs.

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions and evidence presented, finds and concludes that the Intermediaries' adjustments should be reversed. The stock maintenance costs incurred by the Providers or allocated to them by their home office are allowable Medicare costs and these costs are not included in the rate of return on equity capital.

The Social Security Act and Regulation 42 CFR 405.451 require reimbursement of all costs incurred by a provider if such costs are reasonable, necessary and related (directly or indirectly) to the care of the program's beneficiaries. Section 1861(v)(1) of the Social Security Act provides the following:

> (A) The reasonable cost . . . shall be the cost actually incurred . . . and shall be determined in accordance with regulations establishing the method . . . , and the items to be included . . . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services . . .
>
> (B) Such regulations in the case of . . . services furnished by proprietary facilities shall include provisions for specific recognition of a reasonable return on equity capital, including necessary working capital in the facility . . . The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services . . . shall not exceed one and one-half times the average of the rates of interest . . . on obligations issued by the Federal Hospital Insurance Trust Fund.

In defining cost related to patient care, the regulations at 42 CFR 405.451 state:

> . . . All payments . . . must be based on the reasonable cost of services covered under title XVIII of the Act . . . . . Reasonable cost includes all necessary and proper costs incurred in rendering the services . . .
>
> . . . Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity. . . .

The Board believes that expenses designated "stock maintenance" costs are essentially the same as those incurred by any provider, including a not-for-profit hospital, to maintain its existence in the corporate form and/or to

raise capital through debt financing. The only basic difference between raising capital through stock issuance versus debt financing is that some portion of the stock maintenance costs is incurred to enable the providers to maintain access to the equity financing market. The appropriateness of and need for such costs is recognized in 42 CFR 405.429 which states in pertinent part:

> (a)(1) A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers;
>
> (b)(1) A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion;
>
> (b)(4) Return on investment as an element of allowable cost is subject to apportionment in the same manner as other elements of allowable costs.

It is the Board's opinion that stock maintenance costs benefit patients and must be considered as allowable costs. If this is not done, the return on equity is diminished contrary to the intent of Congress. In order to apply 42 CFR 405.429(b)(4), stock maintenance costs should be treated like all other administrative and general expenses for purposes of cost finding and apportionment. While the Board believes that the Intermediaries properly followed the instructions in Section 2134.9 of HIM 15-1, it is the Board's conclusion that this manual provision is not consistent with, and is a misapplication of, the law and regulations.

The Board finds no support for the contention that "stock maintenance costs" are included as part of the rate of

return paid on equity capital. Neither the statute, nor the regulations, nor the legislative history, contain any evidence that Congress intended for Medicare to apply the term "return on equity" in any manner that differed from its plain language meaning, namely to provide a return to the investor in the context of the financial marketplace.

The Court of Claims took a similar position in *AMI-Chanco, Inc. v. U.S.*, U.S. Ct. of Claims, 576 F2d 320, (1978), as indicated by the following statement:

> Furthermore, we find unconvincing the government's argument that Congress demonstrated its intention to reimburse stock maintenance costs as part of the rate of return on equity by not enacting the section providing for a rate of return until a year or so after the original Medicare legislation was passed. If the delay in enactment of Section 1395x(v)(1)(B) means anything at all, we think it indicates a Congressional intent that the rate of return on equity capital was to be allowed, wholly apart from, and independent of, other indirect costs, such as stock maintenance costs.

In prior decisions on this issue, the Board has consistently found that stock maintenance costs were similar to other allowable indirect administrative and general expenses incurred by providers in the provision of patient care services. Since the Medicare program neither restricts nor gives preference to a particular type of ownership/organization structure for participating providers, it is inconsistent and unreasonable for the program to selectively deny costs which must be incurred by corporate proprietary institutions in order to maintain their organizational entity and provider capability. Moreover, 42 CFR 405.402(b) expressly mandates that payment polices not

discriminate between providers based on corporate form. Accordingly the Board disagrees with court rulings that either ignore or fail to properly consider reasonable and necessary costs that are innate to certain organizational entities that are recognized and encouraged to participate in the Medicare program.

For example, in *Sun Towers, Inc. v. Heckler*, CA-5, 725 F2d 315 (1984), while the court recognized that stock maintenance costs may be ordinary and necessary business expenditures of a corporate provider, that the incurrence of some of these costs may be legally required to maintain corporate status, that some of the activities that give rise to stock maintenance costs are required by law, and that stock maintenance costs may benefit medical services by assisting in the attraction of equity capital, the court, nevertheless, concluded that such costs were not necessary to furnishing medical care. The Board respectfully disagrees. Stock maintenance costs are necessary to maintain the existence of a hospital which has a legitimate right to exist as a proprietary institution. Thus, the Board disagrees with the primary purpose analysis of the court and believes stock maintenance costs are related to patient care.

In the case of *Humana, Inc., et al. v. Heckler*, CA (D. of C.), 758 F2d 696 (1985), the court stated the following:

> In the case of stock maintenance costs, submitting SEC filings, paying stock transfer fees, and conducting and reporting on shareholder meetings all serve to protect the shareholders and to enhance their investment. While the indirect effect of stock maintenance activities may sometimes benefit medical services, the connection is too indirect. The Act gives no preference to one

> particular organizational structure. It should not, therefore, subsidize the continuing costs of a provider's choice of corporate structure.

While the court is stating that the Medicare program should not dictate the type of organization structure for providers or give preference to one particular structure, the court, by its decision, is in fact giving preference to the nonprofit organization structure.

The court goes on to state:

> The Act is structured to encourage the creation of medical facilities. Incorporation and the securing of adequate debt financing bring such facilities into existence. Reimbursement for these expenses is consistent with the intent of the Act. Once a facility is in existence and medical services are being rendered, however, stock maintenance costs inure primarily to the benefit of shareholders, not patients.

The Board finds it perplexing that the Medicare program would encourage the creation of corporate entities to bring medical facilities into existence, and then deny the costs of maintaining the entities once such facilities are in existence. If the corporate entities are unable to maintain their existence, the medical facilities would also cease to exist. Such contradictory policy is not consistent with the intent of the Medicare program. The Board believes the establishment of any sort of organizational preference or abandonment of the statutory non-preference would constitute such a significant departure from the law and past practice as to require the promulgation of a new rule in accordance with the APA.

DECISION;

The stock maintenance costs incurred by the Providers and/or allocated to them by their home office are allowable costs under Medicare law and regulations. The Intermediaries' adjustments are reversed.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Phyllis E. Bernard
Keith E. Braganza

FOR THE BOARD:

JUL 21 1988

/s/ Elise D. Smith
Elise D. Smith
Chairman

SCHEDULE OF PROVIDERS IN GROUP JAL:83-1000G

Group Name – National Medical Enterprises, Inc.
Group Representative – Hooper, Lundy & Bookman, Inc.
Group Case No. – 83-1000G

Common Issue – Stock Maintenance Costs

Provider Number	Provider Name	Amount of Medicare Reimbursement in Controvery Cost Reporting Year 1974	1975	1976	1977	1978	1979	FISCAL INTERMEDIARY
05-0583	Alvarado Community Hospital	2023	3152	11551	4658	6969	8055	Aetna
05-0307	Chico Community Memorial Hospital	1332	1923	7063	4385	4488	5669	Aetna
05-0034	Dominquez Valley Hospital	546	1006	6460	2277	3584	4728	Aetna
05-0432	Garfield Medical Center	2636	3330	12055	6848	8138	10136	Aetna
05-0581	Doctors Hospital of Lakewood	1685	3532	12694	6406	8137	11244	Aetna
05-0442	Lodi Community Hospital	1047	1278	4807	2397	2619	3610	Aetna
05-0156	Los Altos Hospital	710	1450	5518	3229	3948	4831	Aetna
05-0118	Manteca Hospital	–	–	–	–	634	2004	Aetna
05-0464	Doctors Hospital of Modesto	3426	4143	16059	7881	9473	13900	Aetna
05-0584	Doctors Hospital of Montclair	773	1217	4154	1845	2475	2950	Aetna
50-0020	Northgate General Hospital	1173	1637	5336	2743	2927	–	Aetna
05-0046	Ojai Valley Community Hospital	477	741	2524	1136	1375	1458	Aetna
05-0522	Doctors Hospital of Pinole	–	–	–	–	–	5369	Aetna
05-0312	Memorial Hospital of Redding	1173	1896	5980	3164	3725	5241	Aetna
05-0314	Turlock Community Hospital	748	960	3307	1550	–	–	Aetna
05-0041	Ontario Community Hospital	–	–	–	–	2764	4249	Blue Cross of California
45-0668	Sierra Medical Center	–	–	–	–	4613	7447	BC/BS of Texas, Inc.
05-0633	Twin Cities Community Hospital	–	–	–	–	1724	3171	Mutual of Omaha
	TOTAL (Rounded)	11750	26266	97507	48518	67594	94061	

HEALTH CARE FINANCING ADMINISTRATION

Decision of the Administrator

In the Case of:	**Claim for:**
NATIONAL MEDICAL ENTERPRISES, INC. GROUP APPEAL Provider **vs.** AETNA LIFE AND CASUALTY COMPANY Intermediary	Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending 12/31/1974, 1975, 1976, 1977, 1978, 1979 **Review of:** PRRB Decision No. 88-D26 Dated: June 21, 1988

This appeal is before the Administrator, Health Care Financing Administration, for review of the decision of the Provider Reimbursement Review Board. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 USC 139500]. The parties included in this Administrator's decision were notified of the intent to review the Board's decision. Comments were received from the Intermediary requesting the Board's decision be reversed and from the Providers requesting that the Board's decision be affirmed. Accordingly, this decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

This issue concerns whether stock maintenance costs are allowable under Medicare. The Board held the stock maintenance costs are related to patient care and are

allowable costs under Medicare law and regulations. The Board referred to the Court of Claims decision in *AMI-Chanco, Inc. v. U.S.*, 576 F.2d 320 (Ct. Cl. 1978) in support of its position that these costs are allowable. The Board disagreed with the courts' holdings in *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir. 1984) and *Humana, Inc. v. Heckler*, 758 F.2d 696 (D.C. 1985). It found that those cases either ignored or failed to properly consider reasonable and necessary costs that are innate to certain organizational entities that are recognized and encouraged to participate in the Medicare program.

SUMMARY OF COMMENTS

The Providers contended that the Administrator is bound by the doctrine of collateral estoppel (or related doctrine) to affirm the Board's decision. The Providers cited *National Medical Enterprises v. U.S.*, No. 742-85C (Cl. Ct. Dec. 10, 1986) in which the court granted judgment for National Medical Enterprises (NME) and three providers in this case, for the same stock maintenance issue for pre-1973 fiscal years.

The Providers stated that *Pacific Medical Enterprises v. Harris*, 633 F.2d 123 (9th Cir. 1980), requires the Medicare program to apply the concept of collateral estoppel to avoid relitigation of issues decided by the courts for earlier fiscal years. The Providers noted that this is the same circuit which would review and reversal of the PRRB and is therefore persuasive in the instant case.

The Intermediary commented that the Board's decision was contrary to Section 1861(b)(1)(A) of the Social Security Act as well as the Medicare Regulations 42 CFR 413.9

(formerly designated as 42 CFR 405.451). The Intermediary stated that these costs are not necessary and proper for patient care. That these costs are not allowable has been sustained by the court in *American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 677 F. 2d 118 (D.C. 1981).

DISCUSSION AND EVALUATION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments received timely are included in the record and have been considered.

Consistent with Medicare policy, Sections 2150.2B and 2134.9 of the Provider Reimbursement Manual (HIM-15) specify that stock maintenance costs are costs of the home office corporation which are not subject to allocation to each of the Providers in the chain organization for Medicare reimbursement purposes. Although there is no reference to these specific costs in either the Act or the regulations, these two sections in the Manual provide an interpretation of the regulations concerning whether stock maintenance costs are related to patient care. Section 2150.2B of the Manual describes the home office costs which are not considered allowable. This section refers to Section 2134.9 in disallowing stock maintenance costs because they "are not related to patient care . . . " and are "incurred primarily for the benefit of stockholders or other investors."

Stock maintenance costs include costs associated with stockholders' meetings, legal and accounting fees related

to SEC filing requirements, annual stockholders reports, stock transfer and registration fees, and public relations costs relating to stock and financial matters. The fact that all of these costs may be necessary to the home office corporation to maintain its corporate existence, does not alter the fact that these costs are not related to patient care under the regulations and the interpretative Manual sections.

These sections of the Manual are consistent with both the Social Security Act and the regulation at 42 CFR 413.9 which define "reasonable cost." In order for a cost to be reimbursable under the program, it must, among other limitations, be related to patient care. No matter how necessary stock maintenance costs may be to the corporation in maintaining its corporate status, these costs cannot be construed as related to the patient care services of the Providers since patient care services do not generate such costs. Further, costs that are not necessary for the efficient delivery of needed health services are not reimbursable under Section 1861(v)(1)(A) of Title XVIII of the Social Security Act, as amended [42 USC 1395x].

Reasonable cost for program reimbursement purposes is defined in Section 1861(v)(1)(A) of the Act. This section requires that "reasonable cost . . . be the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included . . . " The regulations, at 42 CFR 413.9(a), state that payments to providers "must be based on the reasonable cost of services covered under Medicare and related to the care

of beneficiaries." Reasonable cost includes "necessary and proper costs incurred in furnishing the services . . . "

The individual Providers did not receive any patient care related benefits as a result of the Parent company incurring stock maintenance costs to maintain its own corporate status and equity capital. The relationship between the Parent Corporation and the Providers does not bestow a right to shift costs applicable only to the home office corporation to the Providers with the resultant effect of obtaining Medicare reimbursement for such costs.

To the extent that the Parent Company incurred patient costs directly for the Providers, such costs are included in the Providers' allowable costs under the regulations, and as explained in Section 2150.2B of the Provider Reimbursement Manual (HIM-15). Such costs incurred by the Parent Company are considered by the program to be home office costs. Where home office costs are not otherwise allowable costs when incurred directly by the Providers, these costs may not be allowable as home office costs to be allocated to the Providers. This Manual Section is a proper interpretation of the Act and 42 CFR 413.9 in that home office costs must be related to patient care services furnished by providers in order to be allowable under the program.

Patient care services may be rendered without incurring stock maintenance costs. It is the construction of the organizational entity providing the services which gives rise to stock maintenance costs. It is recognized that some stock maintenance costs are necessary for a publicly held corporation to maintain its corporate status. However,

these costs are not related to the care of beneficiaries as required by 42 CFR 413.9(a) for Medicare reimbursement.

The courts have consistently upheld the Secretary's decision on this issue for cases involving post-1972 cost years. *American Medical International, Inc. v. Secretary of Health, Education and Welfare,* 677 F. 2d 118 (D.C. 1981), *Humana, Inc. v. Heckler,* 758 F. 2d 69[illegible] (D.C. 1985), *Sun Towers v. Heckler,* 725 F.2d 315 (5th Cir. 1984).

Additionally, the case law does not support the Providers' contention that the Administrator is bound by the doctrine of collateral estoppel to affirm the Board's decision. The issue of collateral estoppel was similarly examined by the court in *American Medical International v. Secretary of Health, Education and Welfare,* 677 F. 2d 118 (D.C. 1981). In that case the issue was raised as to whether the Administrator was collaterally estopped from withholding reimbursement of stock maintenance costs, which had been earlier decided against the government in *AMI-Chanco v. United States,* 576 F.2d 320 (Ct.Cl. 1978).

Upon similar facts as those here, the court determined that the government should not be collaterally estopped from withholding reimbursement, even for providers involved in the earlier litigation for pre-1973 cost years. The court found that special circumstances warrant an exception to the normal rules of issue preclusion and that collateral estoppel is not meant to create vested rights in decisions thereby causing inequities among similarly situated parties.

The Ninth Circuit, in *Railway Labor Executives' Association v. I.C.C.,* 784 F. 2d 959, 964 (9th Cir. 1986), cited with

approval the D.C. Circuit's holding in *American Medical International* on the issue of collateral estoppel of the government. In doing so, the Ninth Circuit stated that there are persuasive and powerful reasons for rejecting the application of collateral estoppel. Accordingly, the Administrator does not find support in either the Ninth Circuit or D.C. Circuit for the Provider's contention that the Administrator must affirm the Board's decision on the basis of collateral estoppel.

FINDINGS OF FACTS

1. The Providers are short-term, general acute care hospitals operated by NME.

2. NME is a home office, as defined by Section 2150 of the Provider Reimbursement Manual (HIM-15), which incurred the corporate stock maintenance costs.

3. The stock maintenance costs were incurred by the home office to maintain its corporate status.

CONCLUSIONS OF LAW

1. Stock maintenance costs are not necessary for the Providers' efficient delivery of health services covered by Medicare under Section 1861(v)(1)(A) of the Social Security Act, as amended, [42 USC 1395x].

2. Stock maintenance costs are not related to the care of beneficiaries as required by 42 CFR 413.9(a).

3. Stock maintenance costs are not necessary and proper costs appropriate and helpful in developing and maintaining the operation of patient care facilities, and are not

common and accepted occurrences in the field of the Providers' activities as required by 42 CFR 413.9(b)(2).

4. The claimed maintenance costs are specifically excluded from the program reimbursement and are in excess of costs necessary for needed health services under 42 CFR 413.9(c)(3) as interpreted by Section 2134.9 and 2150.2B of the Provider Reimbursement Manual (HIM-15).

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NATIONAL MEDICAL ENTERPRISES, INC., Doing Business Through Various Wholly-Owned Hospital Subsidiaries, Plaintiff-Appellee, v. LOUIS W. SULLIVAN, M.D., Secretary of Health and Human Services, Defendant-Appellant.	No. 89-55859 D.C. No. CV-89-0072-JSL ORDER FILED Nov 29 1990

Before: NELSON, NORRIS and O'SCANNLAIN, Circuit Judges

The panel, as constituted above, has unanimously voted to deny the petition for rehearing and to reject the suggestion for a rehearing en banc.

The full court has been advised of the suggestion for en banc rehearing and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is **DENIED**, and the suggestion for a rehearing en banc is **REJECTED.**

(b) Amount paid to provider of services

The amount paid to any provider of services (other than a hospice program providing hospice care) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be –

> (1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services;

* * *

* * *

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulation may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs

necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

§ 1395oo. Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the

rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) Right to counsel; rules of evidence

At such hearing, the provider of services shall have the right to be represented by counsel, to introduce

evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissable under rules of evidence applicable to court procedure.

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) Rules and regulations

The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to

review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control must be brought by such provider as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time the civil aciton authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) Technical and clerical assistance

The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

§ 413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 413.13.

(b) *Definitions* – (1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of provider's activity.

(c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items

or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

[51 FR 34795, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986]

§ 413.153 Interest expense.

(a)(1) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest costs are not allowable if incurred as a result of –

(i) Judicial review by a Federal court (as described in § 413.64(j));

(ii) An interest assessment on a determined overpayment (as described in § 405.376 of this chapter); or

(iii) Interest on funds borrowed to repay an overpayment (as described in § 413.64(j) or § 405.376 of this chapter), up to the amount of the overpayment, unless the provider had made a prior commitment to borrow funds for other purposes (for example, capital improvements).

(2) *Exception.* In those cases of administrative or judicial reversal, interest paid on funds borrowed to repay an overpayment is an allowable cost, in accordance with this section.

(b) *Definitions* – (1) *Interest.* Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary.* Necessary requires that the interest be –

(i) Incurred on a loan made to satisfy a financial need of the provider. Loans that result in excess funds or investments would not be considered necessary;

(ii) Incurred on a loan made for a purpose reasonably related to patient care; and

(iii) Reduced by investment income except if such income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds. Income from funded depreciation or a provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court (as described in § 413.64(j)) is not used to reduce interest expense.

(3) *Proper.* Proper requires that interest be –

(i) Incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

(ii) Paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or the provider's qualified pension fund.

(c) *Borrower-lender relationship.* (1) Except as described in paragraph (c)(2) of this section, to be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors

could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in armslength transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. If the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, if interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans is treated as invested funds in the computation of the provider's equity capital under § 413.157.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider

operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) If funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment is accorded deposits in the provider's qualified pension fund if such deposits are used for other than the purpose for which the fund was established.

(d) *Loans not reasonably related to patient care.* (1) The following types of loans are not considered to be for a purpose reasonably related to patient care:

(i) For loans made to finance acquisition of a facility, that portions of the cost that exceeds –

(A) Historical cost as determined under § 413.134(b); or

(B) The cost basis determined under § 413.134(g); and

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed under § 413.134(k).

(2) In determining whether a loan was made for the purpose of acquiring a facility, we will apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill, and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we will apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not

covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill.

(e) *Limitation on Federal participation for capital expenditures.* The allowance for depreciation is not an allowable cost for certain capital expenditures as described in § 413.161.

§ 405.1837 Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if –

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or HCFA Rulings; and

(3) The amount in controversy is, in the aggregate, $50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the aggregate, $50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

[48 FR 39836, Sept. 1, 1983]

Bond Discount and Expenses (Prov. Reimb. Man., Part I, § 212.1)

Where bonds are sold at a price below par or face value, the difference between par and selling price represents the amount of discount. Bond discount is, in effect, an adjustment of the interest rate, a premium which the issuing company allows to the purchaser to induce him to buy the bonds at the interest rate stated for the bonds. The discount is considered to be additional interest expense paid in advance and, therefore, is includable in allowable cost. The discount, together with any expense related to the issue, is amortized over the period from the date of sale to the date of maturity of the bonds. Amortization may be made on the straight-line method or by the effective interest method whichever is customarily used by the provider.

Bond expense is the cost of floating a bond issue. Usually, it is made up of legal, accounting, appraisal and engineering fees, registration and printing of the bonds.

.01 Source:

As adopted, Trans. No. 4 (Nov. 1968).

(Prov. Reimb. Man., Part I, § 2134)

Organization Costs – General (Prov. Reimb. Man., Part I, § 2134.1)

Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible assert in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

A. *Allowable Organization Costs.* – Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

B. *Unallowable Organization Costs.* – The following types of costs are not considered allowable organization costs; costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal Authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, 1976.

Cost Treatment of Organization Costs Under Medicare (Prov. Reimb. Man., Part I, § 2134.2)

A. *Providers Entering Program After June 30, 1976.* – Allowable organization costs should generally be capitalized by the organization. However, if in the opinion of the intermediary, these costs are not material when compared to total allowable costs, they may be included in allowable costs for the initial cost reporting period. Otherwise, allowable organization costs are amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

If the provider enters the program after 60 months starting with the month the first patient is admitted for treatment, no organization costs are recognized. Organization costs can be capitalized retroactively (reduced for any periods already elapsed from the time the first patient was admitted for treatment) where a provider (1) did not initially capitalize organization costs (or has written off such costs in the period(s) incurred) before entering the program; (2) can establish these costs to the satisfaction of the intermediary; and (3) enters the program within 60 months after the first patient was admitted for treatment.

B. *Providers Entering Program Before July 1, 1976.* – Where a provider enters the program before July 1, 1976, and capitalizes organization costs, the provider may continue to amortize the organization costs ratably over a period of 60 consecutive months beginning with the date of organization. However, if the organization costs were considered to be immaterial by the intermediary, the costs may be included in the provider's allowable costs in the cost reporting period(s) incurred.

Stockholder Servicing Costs (Prov. Reimb. Man., Part I, § 2134.9)

The following types of costs relevant to the proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

.01 Source:

As adopted, Trans. No. 75 (Aug. 1973).

HOME OFFICE COSTS – CHAIN OPERATIONS (Prov. Reimb. Man., Part I, § 2150)

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§ 1002.2 [¶ 5685] and 1002.3 [¶ 5688] for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where § 1010 [¶ 5712] is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in § 2153 [¶ 5999V-75].

Section 2150 is not applicable to franchise fees (see §§ 2135ff. [¶ 5977 *et seq.*]), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see § 1010 [¶ 5712]).

.01 Source:

As adopted, Trans. No. 68 (Jan. 1973), and amended by Trans. No. 70 (Apr. 1973) and by Trans. No. 167 (Sept. 1976).

General Limitation on Allowability of Costs (Prov. Reimb. Man., Part I, § 2150.1)

Where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are subject to the provisions of Chapter 10 [¶5679 *et seq.*]. Thus, allowable cost is limited to the lower of (1) allowable costs properly allocated to the provider, except as indicated in § 1010 [¶5712], or (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chainwide basis.

.01 Source:

As adopted, Trans. No. 68 (Jan. 1973).

Determination of Allowable Costs (Prov. Reimb. Man., Part I, § 2150.2)

A. *General.* – Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.), are allowable to the extent they are reasonable (see § 2102.1 [¶5858]). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see § 2136.2 [¶5996B]), some franchise taxes and other similar taxes (see § 2122.4 [¶5934]), costs of noncompetition agreements (see § 2105.1 [¶5875]), certain life insurance premiums (see § 2130 [¶5960]), certain membership costs (see §§ 2138.3 [¶5997C] and 2138.4 [¶5997D]) or those costs related to non-medical enterprises are not considered allowable home office costs. In addition, where an owner of the provider, as defined in Chapter 9 [¶5579 *et seq.*] received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see § 902.2 [¶5588]) and to the extent that it is reasonable (see § 902.3 [¶5591]).

B. *Organization, Start-Up, and Other Corporate Costs.*–

1. *Organization Costs.* – The organization costs of a home office *(except those referred to below)* are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in §§ 2134ff [¶5978 *et seq.*]. Section 2134.1B [¶5978] describes costs which are not considered allowable organization costs. In

addition, reorganization costs (see § 2134.10 [¶5994A]) and stockholder servicing costs (see § 2134.9 [¶5994]) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.

* * *

D. *Interest on Loans from Unrelated Sources.* – Interest expense (see § 200ff [¶4096 *et seq.*]) is allowable to the extent that the proceeds of the related loan, mortgage, bond issue, etc., are used either to acquire assets for use in patient care activities (capital related) or to provide funds for operations related to patient care (noncapital related). The interest expense must be reduced by investment income as defined in § 202.2 [¶4920]. For the allocation of interest expense and investment income, refer to § 2150.3.E [¶5999V-3]. Where proceeds of a loan, mortgage, bond issue, etc., are used to acquire stock ownership (as opposed to assets and liabilities) of additional facilities, the interest expense is not allowable.

.01 Source:

Ad adopted, Trans. No. 68 (Jan. 1973), and amended by Trans. No. 113 (Feb. 1975), by Trans. No. 167 (Sept. 1976), by Trans. No. 173 (Apr. 1977), by Trans. No. 184 (Oct. 1977), by Trans. No. 206 (July 1978), by Trans. No. 215 (Jan. 1979) and by Trans. No. 315 (Dec. 1984).

Former Section 2150.6, as adopted by Trans. No. 149 (May 1976), was incorporated into Sec. 2150.2 as new Subsec. E by Trans. No. 167.

Allocation of Home Office Costs to Components in Chain (Prov. Reimb. Man., Part I, § 2150.3)

A. *Procedure.* – Starting with its total costs, including those costs paid on behalf of providers (or other components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions. The remaining costs (total allowable costs) will then be identified as capital-related costs and noncapital-related costs and allocated as stated below to all the components – both providers and nonproviders – in the chain which received services from the home office.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation bases used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonpatient care activities as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general and administrative costs.

B. *Costs Directly Allocable to Components.* – The initial step in the allocation process is the direct assignment of costs to the chain components. Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the chain entity for which they were incurred. For example, where such costs are paid by the home office, interest expense is allocated to the facility for which the loan was made; salaries are allocated to the facility to whose employees they apply; etc. Home offices

may simplify the allocation of costs to the chain components in the cost finding process by transferring the costs which are directly allocable to the components through the intercompany accounts. The transfer should be made at the time the costs are incurred.

C. *Costs Allocable on a Functional Basis.* – The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain. Chain home offices may provide certain centralized services, such as central payroll or central purchasing, to the chain components. Where practical and the amounts are material, these costs must be allocated on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued; the costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Any residual allowable home office costs remaining after a functional cost allocation has been completed must be included as pooled costs and allocated as described in subsection D., below. The functions, or cost centers used to allocate home office costs, and the unit bases used to allocate the costs, including those for the pooled costs described in subsection D., must be used consistently from one home office accounting period to another.

However, if the home office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the home office must make a written request, with its justification, to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

D. *Pooled Costs in Home Office.* – In each home office there will be a residual amount, or "pool," of costs incurred for general management or administrative services which cannot be allocated on a functional basis. For home office accounting periods beginning before November 1, 1976, these costs may be allocated to the components in the chain on the basis of beds, bed days, or other basis, provided the basis used equitably allocate such costs. Revenues are not generally appropriate for distributing these costs. Where the home office cannot determine its costs by functions and allocate them on a functional basis, the home office must allocate its costs as one cost center of pooled costs.

1. For home office accounting periods beginning on or after November 1, 1976, but beginning before January 1, 1983, the pooled costs of the home office must be allocated to the chain components in accordance with the following:

a. Where the chain consists solely of health care facilities, the pooled costs must be allocated to the components based on either inpatient days or total costs. If inpatient days are used, each facility would share in the pooled costs in the same proportion that its inpatient days bear to the total inpatient days of all the facilities in the chain. The basis of inpatient days can be used only if the entire chain consists soley of inpatient health care facilities. If the chain consists of both inpatient and noninpatient type[s] of [facilities], total costs must be used as the basis of allocation. If total costs are used, each facility would share in the pooled costs in the same proportion that its total costs (excluding home office costs) bear to the total costs of all facilities in the chain. Total costs are costs before Medicare adjustments are made.

b. Where the chain consists of health care facilities *and* organizations carrying on other types of activities, such as pharmacies, construction companies, etc., the pooled costs may be allocated to the health care facilities and nonhealth care organizations on an appropriate basis depending upon the organization of the chain. The intermediary would be responsible for reviewing and approving the basis used. After this initial allocation, the pooled costs allocated to the health care facilities must then be allocated to each separate facility as set forth in a., above.

HOME OFFICE EQUITY CAPITAL (Prov. Reimb. Man., Part I, § 2152)

Computation (Prov. Reimb. Man., Part I, § 2152.1)

Where a chain provider receives services from the home office and the program recognizes the costs of such services for reimbursement purposes (see § 2150.1 [¶5999V-1]), the provider must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care, as defined in § 1202.1 [¶5762]. In the determination of home office equity capital, assets and liabilities not related to patient care activities are excluded in the computation.

The equity capital of the home office is computed generally in the same manner as for providers (see chapter 12 [¶5758 *et seq.*]). That is, a calculation is made at the end of the home office's accounting period to analyze the equity capital and changes therein during the period and to determine the amounts of home office equity capital at the end of each month in the period. However, where a negative amount is shown in the home office equity capital balance for any month, the actual negative amount of equity capital is included for that month in the provider's cost reports to determine the provider's average equity capital.

.01 Source:

As adopted, Trans. No. 167 (Sept. 1976).

Former Section 2150.4, as adopted by Trans. No. 68 (Jan. 1973), and amended by Trans. No. 131 (Sept. 1975), was replaced by new Sections 2152.1 and 2152.2 by Trans. No. 167.

Allocation of Home Office Equity Capital (Prov. Reimb. Man., Part I, § 2152.3)

After the home office equity capital is determined in accordance with §§ 2152.1 [¶ 5999V-50] and 2152.2 [¶ 5999V-51], the home office equity capital must be allocated to the providers and other components in the chain (including nonhealth care areas) which receive services from the home office. Any assets and liabilities on the financial records of the home office, and includable in equity capital of the home office, which are directly attributable to a particular provider or other entity in the chain, must be allocated directly to the particular provider or other entity in the chain and included in that entity's equity capital. For example, where the home office purchases equipment and transfers it to a provider, the equity in the equipment must be directly allocated to that provider. In the same manner, if the home office borrowed funds to finance the purchase of the equipment, the liability must also be allocated directly to the provider and included in the provider's equity capital computation.

Where borrowed and internally generated funds are transmitted by the home office to the providers or other entities in the chain and the funds have become so commingled as to preclude separate identification, the liability for the borrowed funds is allocated to the providers and other entities in the chain in the proportion that the funds received by that provider or other entities bear to total funds disbursed.

The equity in those assets and liabilities which are directly allocable to a particular provider must be included in the computation of the average equity capital

of the provider on a monthly basis. The effect of this would be the same as if the provider itself owned the assets and owned the liabilities. Home offices can simplify the computation of home office equity capital and the allocation of equity capital to the chain components in the cost finding process by transferring the assets and liabilities which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the assets and/or liabilities become directly allocable.

The remaining home office equity capital, or "pooled" equity capital, related to patient care and computed under § 2152 [¶ 5999V-50 *et seq.*] must be allocated to each provider and other entity in the chain. The basis used for the allocation of pooled equity capital is the ratio that the portion of home office *costs* allocated to each provider or other entity bears to total home office costs. Home office costs which are directly allocable to a provider or other component in the chain (see § 2150.3B [¶ 5999V-3]) should be excluded from the allocation base used to allocate "pooled" equity. The ratio developed for the allocation of home office equity capital must be applied to the amount of equity capital computed at the end of each month in the computation of average equity capital of the home office. In effect, the home office equity capital is considered as a group of net assets used to provide services to the providers and other entities in the chain.

The costs of these services allocated to the providers are considered to be a measure of the degree to which the related equity capital is used for the benefit of the providers. Each provider must include its allocated share of

the pooled equity capital of the home office at the end of each month in the computation of its total equity capital for each respective month to determine its combined average equity capital upon which the return on equity capital is based.

.01 Source:

As adopted, Trans. No. 167 (Sept. 1976), and amended by Trans. No. 193 (Feb. 1978).

Former Section 2150.3 as adopted by Trans. No. 68 (Jan. 1973), was replaced by new Section 2152.3 by Trans. No. 167.

REPORTING OF HOME OFFICE COSTS AND EQUITY CAPITAL (Prov. Reimb. Man., Part I, § 2153)

Each intermediary servicing a provider in a chain must be furnished with a detailed home office costs statement as a basis for reimbursing the provider for home office costs and equity capital. The home office cost statement must be prepared as of the end of the home office accounting year, setting forth home office costs and equity capital for the accounting year then ended. Only one copy of the cost statement is required for each intermediary regardless of the number of providers in the chain the intermediary is servicing. The home office cost statement may be obtained either form the chain provider or from the chain home office.

The home office cost statement constitutes the documentary support required of the provider to be reimbursed for home office costs and equity capital in the provider's cost report. The financial records of the home office, in turn, are the necessary support for the data in the home office cost statement. Preparation of, and furnishing, the home office cost statement then is a home office responsibility. If a provider or the home office does not furnish a home office cost statement to the intermediary, the intermediary will not have adequate data to support payments for home office costs and equity capital and must delete home office costs and equity capital allocations from reimbursement. Corresponding changes would be made to interim rates of reimbursement affected by the deletion of home office costs.

Since the intermediary must have an acceptable home office cost statement before it can reimburse the provider for home office costs and equity capital, the cost

statement should be furnished to the intermediary within 90 days after the close of the home office accounting year. Timely furnishing of the home office cost statement will facilitate the intermediary's settlement of the provider's cost report and reimbursement for the home office costs and equity capital.

To be acceptable, the home office cost statement must be prepared in a format which contains detailed schedules of the determination of home office cost and equity capital and their allocation.

A. *Home Office Costs.* – The determination of allowable costs of the home office should begin with the total cost of the home office, by cost centers, as shown by the home office general ledger trial balance; should show the reductions for those costs which are not allowable; and should then show the adjusted trial balance of total allowable costs. The reduction for unallowable costs should be identified and explained on a supporting schedule.

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT CALIFORNIA

HUMANA, INC., et al., Plaintiffs, v. RICHARD S. SCHWEIKER, Secretary, Department of Health and Human Services, Defendant.	Civil No. C 82-2072-AJZ MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO AFFIRM THE DECISION OF THE SECRETARY AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs, Humana, Inc., and its wholly-owned subsidiary Doctors' Hospital of San Leandro, brought this action to increase their receipts from the Medicare program. Humana challenges longstanding policies that the Medicare program does not pay participating facilities a return on their income tax liabilities or for expenses they incur for the benefit of their stockholders. The Secretary's disallowance of these payments clearly is within the permissible range of his discretion. In addition, the judgment of the United States District Court for the District of

Columbia in *Humana, Inc., et al. v. Schweiker,* Nos. 75-0302, 78-0175, 78-0584, 81-0853, 81-1311 (D. D.C., Aug. 19, 1982) *appeal pending,* collaterally estops plaintiffs from relitigating these issues. Accordingly, the Secretary requests that the Court deny plaintiffs' motion for summary judgment and affirm the administrative decision of the Secretary.

STATUTORY BACKGROUND

Title XVIII of the Social Security Act ("the Act") provides payments for medical care for the aged and certain disabled persons. 42 U.S.C. §1395 *et seq.* Health facilities that elect to participate in the Medicare program file an agreement with the Secretary to treat Medicare patients and to accept Medicare payments for these services, thereby becoming participating "providers of services." 42 U.S.C. §§1395x(u), 1395cc. Participating providers of services are entitled to payment for their services in the amount of the "reasonable cost" of the services furnished to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1).

Section 1395x(v)(1)(A) confers broad discretion on the Secretary to determine the reasonable cost of services. The Act defines the reasonable cost of any services as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . . " *Id.* The statute grants authority to the Secretary to decide "the method or methods to be used, and the items to be included, in determining such costs for various types

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offset by current liabilities.[23] Therefore, to determine net working capital invested in patient care these income tax liabilities must be subtracted from the provider's current assets.

Humana bases its argument on certain PRM provisions that refer to not counting in the equity computation those liabilities that are not related to patient care. However, this exclusion of liabilities is properly limited to liabilities that are strictly tied to assets that are not counted. Thus, if Humana invested in a shopping center, neither the cost of the shopping center nor a mortgage obligation on it would be counted. The asset involved in this case, cash (and other current assets) is included in the equity computation of working capital irrespective of whether its source was profits. These tax liabilities likewise must be counted.

IV. PLAINTIFFS ARE COLLATERALLY ESTOPPED BY THE JUDGMENT IN HUMANA, INC. v. SCHWEIKER

On August 19, 1982, the United States District Court for the District of Columbia handed down its decision in *Humana, Inc., et al. v. Schweiker,* C.A. Nos. 75-0302, 78-0175, 78-0584, 81-0853, 81-1311. In that action Humana, Inc. and 64 of its wholly-owned subsidiary hospital corporations challenged the application to their payments for 1973 through 1977 of the Secretary's policies that

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[23] "Working capital is the difference between current assets and current liabilities." PRM §1201.3.

Medicare does not fund stock maintenance costs and does not pay a return on income tax liabilities. Plaintiffs in the instant action should be collaterally estopped by that judgment from relitigating these issues.

It is well-established that "a 'right, question, or fact distinctly put in issue and directly determined by a court of competent jurisdiction . . . cannot be disputed between the same parties or their privies. . . . ' " *Montana v. United States*, 440 U.S. 147 (1979) *quoting, Southern Pacific R. Co. v. United States*, 168 U.S. 1, 48-49 (1897). Under the doctrine of collateral estoppel, "once an issue is actually and necessarily determined by a court of competent jurisdiction, that determination is conclusive in subsequent suits based on a different cause of action involving a party to the prior litigation." 440 U.S. at 153 (citations omitted). The preclusive effect of a judgment applies both to issues of law and to issues of fact. *E.g., Montana v. United States, supra*, 440 U.S. at 162; *AMI, supra*, 677 F.2d at 120 n. 9; *Monterey Life Systems v. United States*, 635 F.2d 821, 826-827 (Ct. Cl. 1980); *Starker v. United States*, 602 F.2d 1341, 1344 (9th Cir. 1979). Collateral estoppel is less applicable to issues of law than issues of fact only when the subjects of the successive actions are unrelated. 440 U.S. at 162. Where the legal "demands" of the litigation are closely aligned in time and subject matter, collateral estoppel will apply. *Id.* at 163. The policy is one "of protecting litigants from the burden of relitigation of identical issues with the same party or his privy and of promoting judicial economy by preventing needless litigation."[24] *Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 326 (1979).

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[24] These concerns are especially cogent in this case because Humana charges the expenses it incurs in litigation as

(Continued on following page)

It would seem to be beyond any reasonable dispute that the same issues were "actually and necessarily determined" in the D.C. lawsuit. *See Starker v. United States, supra.* The amended complaints in the D.C. litigation are attached as Exhibit A. Human's claim to a right to payment for stock maintenance costs is found in Court V in both No. 81-1211 and Nos. 78-0175, 78-0584. Humana's claim to a return on equity that includes income tax liabilities is found in Count II, paragraphs 48, 49, 53(d), and Prayer for Relief paragraph (c) in Nos. 78-0175, 78-0584, and Count II, Prayer for Relief (e) in No. 81-1311. Humana urged the same arguments in the D.C. case as those presented in the instant case.[25] One difference between the issues in the D.C. case and the present case is

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part of its allowable costs in the Medicare program. Therefore, the public bears not only the Secretary's litigation expenses, but a portion of the expenses that Humana incurs in litigating and relitigating these issues. In addition, judicial resources will be wasted because the court is being asked to review the same administrative records as in the D.C. case. Humana's contention that the Secretary forces providers of services to relitigate issues resolved in their favor year by year, and citation of *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 137 (9th Cir. 1980), is totally baseless. The *Pacific Coast* case merely indicates that the Secretary will not acquiesce in a court ordering injunctive relief for future fiscal years over which Congress has precluded subject matter jurisdiction. The Secretary has applied judicial rulings "in good faith and with expediency." *See, id.*

[25] Defendant will not needlessly multiply these papers by filing briefs from the D.C. case. Should Humana take issue with this appropriate documents will be filed.

that the underlying tax liabilities involved and stock maintenance expenses incurred were those of Humana's predecessor in interest, Medicorp. See Complaint ¶VII. Thus, the dollar amounts of the particular stock maintenance costs and tax liabilities differ from those in the D.C. action. This difference is meaningless because the issues are ones of law.

Differences in the facts should render collateral estoppel inapplicable only if the changes are in facts essential to the earlier judgment. *Montana v. U.S.*, 440 U.S. at 159; *Starker v. United States, supra,* 602 F.2d at 1346-1347. The facts must be of "controlling significance" to the first case to make collateral estoppel inappropriate based on a change in the facts of the two cases. *Id.* at 160. Accordingly, in *AMI* the D.C. Circuit rejected a contention by the government that a prior judgment establishing entitlements for earlier fiscal years could not preclude relitigating the same issue for subsequent years. It explained that the correct legal principle was that unless there were some difference in the facts pertinent to the first decision collateral estoppel should not be denied on this basis. 677 F.2d at 120, 121. This is sound because there is no logical reason why a change in facts that were irrelevant to an earlier decision should prevent an estoppel by judgment in a subsequent case where these facts are equally irrelevant. The legal "demands" of Humana's lawsuits and their subjects are the same, and they are closely aligned in time. Therefore, collateral estoppel applies despite the meaningless factual differences in two cases.

The only other difference between the two cases is the difference in parties. Humana, Inc. was a party to

both actions. However, its wholly-owned subsidiary, Doctors' Hospital, was not a party to the D.C. action. This difference in parties does not prevent estoppel by the earlier judgment, because Doctors' Hospital is likewise bound as a privy of Humana, Inc. and Humana, Inc. controlled both the D.C. lawsuit and the instant case.

The law in the Ninth Circuit is absolutely clear that a close corporation and its sole stockholder are privies. *Sparks Nugget, Inc. v. Commissioner of Internal Revenue*, 458 F.2d 631 (9th Cir.) *cert. denied*, 410 U.S. 928 (1972). Doctors' Hospital is a wholly-owned subsidiary of Humana, Inc. Complaint, ¶¶V-VII. The Ninth Circuit follows a "common-sense approach" to privity in collateral estoppel cases:

> It would seem that the public policy underlying the doctrine of res judicata, as a bar to repetitious litigation, would support a finding of privity between a close corporation and the sole or controlling stockholder.

Id. at 639. Since Doctors' Hospital and Humana, Inc. are privies, Doctors Hospital is equally precluded from relitigating these claims.

Multiple lawsuits on these issues also are precluded because Humana, Inc. controls all of these actions in the furtherance of its own interest. "Courts have recognized that a nonparty may be bound if a party is so closely aligned with its interests as to be its 'virtual representative'." (citations omitted) *United States v. ITT Rayonier, Inc.*, 627 F.2d 996, 1003 (9th Cir. 1980). Thus in *Montana v. United States, supra*, the United States was not allowed to bring a challenge to a state taxing law because it had "directed and financed" an earlier, unsuccessful state

court challenge to the same law by a private litigant. 440 U.S. at 150. Control coupled with a direct financial interest in a lawsuit precludes successive lawsuits controlled by the same entity. *Id.; United States v. ITT Rayonier, Inc., supra; Ritchie v. Landau,* 475 F.2d 151, 155 and n. 2 (2d Cir. 1973); *Eagle Transport Ltd., Inc. v. O'Connor,* 470 F. Supp. 731, 733 (S.D. N.Y. 1979).

Certainly it would be quite an anomaly if Humana, Inc. could bring unlimited successive lawsuits on an issue, each controlled by it and for its financial benefit, based on adding a new, wholly-owned subsidiary in each. A decision in the instant case would be its third on the tax liability issues.[26] As Humana, Inc.'s attorney represented to the Board, "[t]his [Medicorp] appeal is being prosecuted by Humana, Inc. on behalf of the providers." (1982 R. 0407, *see id.* 0204.)[27] To allow Humana to litigate these issues repeatedly until it can find a sympathetic court gives the judicial process "the aura of the gaming table." *Blonder-Tongue Laboratories, Inc. v. University of Illinois Foundation,* 402 U.S. 313, 328 (1971). Humana, Inc. had full and fair opportunity to litigate these issues and, therefore, is precluded.

The final consideration is the affect of the *AMI-Chanco* and *Sun Towers* decisions, *supra.* To the extent that

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[26] *See Humana of Kentucky, Inc. v. Harris, supra.*

[27] Should the Court decide that control by Humana, Inc. is not sufficiently demonstrated on the fact of these records, the Secretary should be allowed an opportunity for discovery to establish this control before an adverse decision on this basis. *See Del Mar Avionics v. Quinton Instrument Co.,* 645 F.2d 832 (9th Cir. 1981).

they merely lend some support to arguments that the D.C. decision is wrong, they are irrelevant. Error in legal conclusion is no basis for denial of collateral estoppel. *Montana v. United States, supra,* 440 U.S. at 162, *citing, United States, v. Moser,* 266 U.S. 236 (1924); *Starker v. United States, supra,* 602 F.2d at 1347 n.3. But there is authority based on *Parklane Hosiery Company v. Shore, supra,* that collateral estoppel would be unfair when there are subsequent, inconsistent decisions. 439 U.S. at 331. This unfairness may even exist when the inconsistent decision is prior to the decision asserted as an estoppel. *Western Oil and Gas Co. v. EPA,* 633 F.2d 803, 809 (9th Cir. 1980).

This consideration, however, does not militate against a collateral estoppel in this case. First, this consideration has arisen in the context of the offensive or defensive use of collateral estoppel by persons who were not parties to the earlier decision, as described in the *Parklane Hosiery* case. 439 U.S. at 330. In this context, the trial courts have been given broad discretion to forgo collateral estoppel based on inconsistent decisions. *See* 439 U.S. at 331; *Western Oil & Gas Co. v. EPA, supra,* 633 F.2d at 809; *Crawford v. Ranger Insurance Co.,* 635 F.2d 1248, 1251-1252 (9th Cir. 1981). The instant case does not involve the discretionary application of collateral estoppel where it is asserted offensively or defensively by third parties, since the only new party is a privy of Humana, Inc. Therefore, traditional principles of collateral estoppel apply. In cases involving traditional collateral estoppel based on mutuality of estoppel between the parties, if there are two prior inconsistent judgments, only the last judgment should be given estoppel effect. *E.g., Restatement (Second)*

of Judgments §41.2 (Tent. Draft No. 1, March 28, 1973); *Restatement of Judgments* §42 (1942). There is no precedent, moreover, for denying collateral estoppel between the *same* parties to successive actions based on inconsistent decisions involving *different* parties.

Finally, it bears noting that the pendency of an appeal does not suspend the operation of a final judgment for collateral estoppel purposes. *E.g., Taunton Gardens Co. v. Hills*, 557 F.2d 877 (1st Cir. 1977); *Nixon v. Richey*, 513 F.2d 430 (D.C. Cir. 1975); 1B J. Moore, *Federal Practice* ¶0.416 (1980). Therefore, Humana should be collaterally estoppel by the D.C. decision both on the tax liability issue and the stock maintenance issue. On the tax liability issue the case law unanimously supports the Secretary. The inconsistent decisions on the stock maintenance issue are prior to the D.C. decision, they involved unrelated parties, and the judgment asserted as an estoppel involved the same parties.

CONCLUSION

Humana sought increased Medicare payments of over $700,000 for its Medicorp holdings for 1974 and 1975. (82 R. 0015.) Humana had no expectation that it would receive these additional payments for its services, since these costs have never been paid by the Medicare program. The Court should take judicial notice of the rapidly increasing costs of health care that are threatening the soundness of the Medicare program. *St. Mary of Nazareth Hospital Center v. Schweiker*, CCH Medicare & Medicaid Guide ¶31,594 (D. D.C. 1981) (copy attached). If the Secretary's policies in these areas are overturned,

annual Medicare expenditures will be inflated by tens of millions. Since these policies are not irrational and arbitrary, a reviewing court should refuse to further the erosion of the Medicare program's viability. Therefore, the decision of the Secretary should be affirmed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the foregoing Memorandum of Points and Authorities in Support of Motion to Affirm the Decision of the Secretary and in Opposition to Plaintiffs' Motion for Summary Judgment was mailed, postage prepaid, this 5th day of November, 1982 to the following:

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¶ 32,912 REVALUATION RESULTING FROM STOCK PURCHASE AND LIQUIDATION – COLLATERAL ESTOPPEL

Humana, Inc. et al. v. Schweiker. U.S. District Court, Middle District of Tennessee, Nashville Division, No. 82-3416, May 19, 1983.

Notices, determinations, and appeals – Court review-legal processes – Collateral estoppel – Revaluation resulting from stock purchase and liquidation. – Where a provider appealed issues involving revaluation of assets resulting from a stock purchase and subsequent liquidation, the sufficiency of the rate of return on equity capital, and the procedural validity of the Secretary's policies on stock acquisitions, but the identical parties had litigated these same issues in a prior lawsuit in another federal court, the court held that it was barred from considering the issues by the doctrine of collateral estoppel. A contrary conclusion was not warranted on the basis of the provider's assertions that (1) the present case involved different cost reporting periods than the earlier decision, and (2) the controlling factual and legal issues have changed subsequent to the issuance of the decision in the other case as a result of court decisions that have adopted the provider's position on the stock acquisition issue. In addition, the provider's claim that collateral estoppel should not be applied on the ground that rigid application of that doctrine forecloses inquiry by other courts was rejected. The provider's claim was estopped because of the prior litigation. Nonparties to that case were not estopped from litigating the same issue in other courts. *Back references:* ¶ 4682.55, 13,540.

HCFA Admr. Dec., Feb. 18, 1982, which reversed PRRB Dec. No. 82-D29, is not reviewable because of collateral estoppel.

[Footnotes at end of decision]

WISEMAN, District Judge: This action arises pursuant to 42 U.S.C. § 1395oo(f)(1) whereby plaintiffs seek to overturn a final decision of the Administrator of the Health Care Financing Administration [HCFA] regarding the amount of reimbursement to which plaintiffs are entitled for services provided to persons insured under the Medicare Act for the cost-reporting periods ending August 31, 1978, and August 31, 1979. Plaintiffs have filed a motion for partial summary judgment. Defendant has filed a memorandum in opposition to plaintiffs' motion in addition to his own motion to dismiss, or in the alternative, for summary judgment.

[*FACTS*]

Plaintiff Humana Inc. [Humana] is a Delaware corporation engaged in providing hospital services through its wholly-owned subsidiaries. Plaintiff Humana of Tennessee was one such subsidiary for the relevant cost-reporting in 1978 and 1979. The Tennessee company operated Nautilus Memorial Hospital, a 52-bed facility in Waverly, Tennessee.

On May 17, 1969, a corporate predecessor of Humana of Tennessee, Inc. acquired one hundred percent of the outstanding capital stock of Nautilus Realty Company, which owned the building, land, assets and liabilities of

Nautilus Memorial Hospital Inc. and Nautilus Pharmacy, Inc. On January 27, 1971, the acquired corporation was liquidated and the corporate predecessor of Humana of Tennessee became the owner of the acquired corporation's assets. The question posed by plaintiffs in this action is whether for Medicare reimbursement purposes the purchase of the outstanding stock of a corporation followed by a merger of the acquired corporation should be treated as an acquisition of assets. Plaintiffs dispute the Secretary's position that such a transaction should not be given the same consideration as a straightforward acquisition of assets. The Secretary, acting through the Deputy Administrator of the Health Care Financing Administration, rejected plaintiffs' request to revalue the acquired assets to reflect the amount that the acquisition cost in excess of the value of the acquired assets as recorded on the books of the previous owner, the acquired corporation.

Under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, "providers" of hospital services, such as plaintiffs, are reimbursed for the cost of services provided to Medicare beneficiaries.[1] Regulations promulgated by the Secretary establish that with respect to services provided Medicare beneficiaries, no part of their cost should be borne by other patients. 42 C.F.R. § 405.402(a); *see also* 42 U.S.C. § 1395x(v)(1)(A). However, reimbursement is limited to "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A).

Included among reimbursable costs are capital costs associated with acquiring and maintaining the necessary

plant, equipment, supplies, etc. used in the delivery of health care. Specifically, these capital costs included depreciation on buildings and equipment, 42 C.F.R. 405.415, and the interest on indebtedness incurred to acquire such assets, 42 C.F.R. 405.419. Additionally, where proprietary (for-profit) institutions are involved, the regulations call for a reasonable return on investment to be included. 42 C.F.R. 405.429.

As required by the Act, plaintiffs submitted claims for the cost-reporting years ending August 31, 1978 and August 31, 1979 to their fiscal intermediary. Plaintiffs' claims were based on a stepped-up cost basis, with the increase over the historical cost representing the stock purchase price for the capital assets of the hospital. The fiscal intermediary disallowed some $62,127 in reimbursement claims resulting from that step-up in plaintiffs' cost basis. Plaintiffs appealed that decision to the Provider Reimbursement Review Board [PRRB] which is an administrative arm of the Department of Health and Human Services. The PRRB reversed the intermediary's disallowance, relying in part on a Ninth Circuit decision allowing an asset revaluation following a stock purchase and merger. *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123 (9th Cir. 1980). The Deputy Administrator of the Health Care Financing Administration, acting for the Secretary, reversed the PRRB decision and disallowed the additional claims. Plaintiffs now appeal to this Court pursuant to 42 U.S.C. § 1395oo(f)(1).

[*Contentions*]

Plaintiffs raise three major claims in this action. First, plaintiffs allege that that Secretary's position contradicts

an established principle in the business, accounting, and tax fields that a stock acquisition followed by a merger of the acquired corporation should be viewed as an acquisition of assets. Plaintiffs contend that the Act's requirements that (1) providers be reimbursed for actual capital costs and (2) the cost of providing care to beneficiaries not be borne by private patients are both violated inasmuch as plaintiffs are not being reimbursed on the basis of their real costs but rather are compensated only for the cost of the facility to the previous owner. Second, plaintiffs allege that certain Medicare regulations were promulgated contrary to the provisions of the Administrative Procedure Act [APA]. Plaintiffs' third major claim is that current regulations do not permit a "reasonable return on equity capital" because the maximum rate allowed is an amount one and one-half times the average rates of interest on certain issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund.

The response by the Secretary addresses these substantive questions and asserts that the Secretary's regulations and actions are valid under the Act. However, the Secretary also asserts as a threshold matter that the doctrine of collateral estoppel acts to bar this action. Because this Court agrees that collateral estoppel principles apply, it is not necessary to reach the substantive claims raised by the complaint.

This action is not the plaintiffs' first attempt to overturn the decision of the Secretary regarding plaintiffs' cost basis in Nautilus Hospital. According to the Secretary,[2] plaintiffs have claimed additional payments for the step-up in basis for each annual cost report since 1973.

The fiscal intermediary has consistently denied the claims and plaintiffs have always appealed to the PRRB. In reporting years 1973, 1976, and 1977, the PRRB accepted the position that in the case of Nautilus, a one hundred percent stock acquisition followed by a merger of the acquired corporation justified a step-up in costs for reimbursement purposes. In these three cases, the Deputy Administrator for the HCFA, acting on behalf of the Secretary, reversed the PRRB decisions in order to enforce the Secretary's position that a purchase of stock in a corporation does not constitute an acquisition of assets.

Humana and its individual hospitals, including Nautilus, challenged the three decisions in an action brought in the District Court for the District of Columbia.[3] That Court affirmed the Secretary's position. *Humana Inc. v. Schweiker*, Nos. 75-0302, 78-0175, 78-0584, 81-0853, and 81-1311 (D.D.C. August 19, 1982).

[*Collateral Estoppel*]

Although the action *sub judice* focuses on the cost reporting years of 1978 and 1979, the Secretary argues that the doctrine of collateral estoppel bars this action because identical parties litigated the very same issues in the prior lawsuit. The Secretary states that the only distinction between the two cases is that the District of Columbia court dealt with the 1973-1977 reporting years, whereas this action involves the 1978 and 1979 reporting years. Thus, the Secretary concludes, plaintiffs are barred from relitigating in this Court issues which have already been resolved by another federal court. The Secretary

finds support for this position in *Montana v. United States*, 440 U.S. 147, 99 S.Ct. 970, 59 L.Ed.2d 210 (1979).

Under the doctrine of collateral estoppel once a court has decided an issue of fact or law necessary to its judgment, that decision may preclude relitigation of the issue in suit on a different cause of action involving a party to the first case. *Allen v. McCurry*, 449 U.S. 90, 94, 101 S.Ct. 441, 66 L.Ed.2d 308, 313 (1980); *Montana v. United States*, *supra*, 440 U.S. at 153. The Court in *Montana* stated that:

> A fundamental precept of common-law adjudication, embodied in the related doctrines of collateral estoppel and res judicata, is that a "right, question or fact distinctly put in issue and directly determined by a court of competent jurisdiction . . . cannot be disputed in a subsequent suit between the same parties or their privies . . . " . . . Under collateral estoppel, once an issue is actually and necessarily determined by a court of competent jurisdiction, that determination is conclusive in subsequent suits based on a different cause of action involving a party to the prior litigation. . . . Application of both doctrines is central to the purpose for which civil courts have been established, the conclusive resolution of disputes within their jurisdictions. [citations omitted] *Id.*

Collateral estoppel serves several salutory functions. "[R]es judicata and collateral estoppel relieve parties of the cost and vexation of multiple lawsuits, conserve judicial resources, and, by preventing inconsistent decisions, encourage reliance on adjudication." *Allen*, *supra*, 449 U.S. at 94.

Plaintiffs cite three grounds in support of their view that collateral estoppel is inappropriate. First, plaintiffs

claim that this case is based on claims arising out of different cost years which were the subject of administrative proceedings independent of those litigated in the District of Columbia and thus, different factual questions are involved. The Court finds it immaterial for present purposes that different claim years are involved. Although the claims submitted by the provider may vary in dollar amount from year to year, the real crux of the matter is what treatment should be afforded the 1969 stock purchase followed by the 1971 merger. The District of Columbia decision did not focus on the varying claim amounts or different facts in each of the three cost-years before the Court. Rather, the decision addressed the same issue now before this Court; i.e., did Humana "acquire the assets" of Nautilus Hospital for purposes of the Medicare regulations. The differences in the various cost-years are not of "controlling significance." *See Montana v. United States, supra,* 440 U.S. at 160. The Secretary accurately points out that the plaintiffs' various allegations in this action were all litigated in the District of Columbia. Plaintiffs claims concerning their right to utilize a stepped-up basis (Counts I, III, IV, and VII herein) were addressed in the prior litigation. The Court described the issue as follows:

> In a number of instances plaintiffs acquired hospital facilities through the purchase of 100% of the stock of the corporations which owned them. In some cases plaintiffs liquidated these corporations, thereby acquiring direct ownership of hospital facilities. In other instances plaintiffs merely took over management and control of the newly acquired corporation and continued its operation of a health care facility. In their claims for reimbursement under the

> Medicare program plaintiffs calculated their capital costs (depreciation on capital equipment, interest expense on loans to finance the acquisition, and a return on capital invested in the facility) on the basis of the price paid to acquire the corporation owning the hospital. That is to say, in all instances plaintiffs attributed the stock purchase price to the tangible and intangible assets of the acquired corporation, and sought reimbursement on a "stepped-up" basis.
>
> The Secretary consistently interpreted 42 C.F.R. § 405.415(8)(h) to encompass only purchases of actual physical assets, and denied plaintiffs reimbursement claims on the grounds that acquisition of the stock of a previous corporate owner of a health care facility does not amount to acquisition of its assets. According to the Secretary, under that interpretation of the regulation no difference in treatment should be made between cases where acquired corporations are liquidated and where they are not. *Humana, supra* at 10, 11.

Count VI of plaintiffs' complaint in this action alleges that the Secretary's regulations do not provide a reasonable rate of return for proprietary providers. Plaintiffs also litigated this issue in the prior action, and their argument was rejected:

> Plaintiffs, Humana, contend that the Secretary's regulations (42 C.F.R. § 405.529) limit the return on the equity capital invested in the hospital's operations to a rate too low to reimburse a facility for the cost of attracting capital that the return on equity is intended to reimburse. The Secretary's position is that the rate of return employed is the maximum allowable under the statute and an adequate reimbursement for the reasonable cost of attracting capital to the corporation. This court finds that the Secretary has

> demonstrated that the rate of return is reasonable. *Id.* at 8.

Finally, plaintiffs' allegations regarding violations of the APA were also disposed of by the Court:

> Humana and its subsidiaries object to the manner in which the requirement policies at issue were promulgated and to the manner in which the Administrator has exercised his decision making authority. Plaintiffs allege that the policies and regulations upon which the Secretary relies to deny the provider-hospitals' reimbursement for stock acquisition costs, income taxes, and stock maintenance costs were all illegally promulgated because they were not subjected to the notice and comment requirements of the Administrative Procedure Act. The Secretary contends that these policies are all interpretive rules, as opposed to substantive rules, and consequently, are exempted from the notice and comment requirements of the Administrative Procedure Act by 5 U.S.C. § 553(b)(A). This court agrees. *Id.* at 15.

Thus, the relevant factual and legal questions in the case are [sic] bar have already been adjudicated by a court of competent jurisdiction.

Plaintiffs' second argument against the application of collateral estoppel is that subsequent to the opinion of the District of Columbia District Court, changes in the controlling factual and legal issues have occurred. Plaintiffs rely on very recent decisions where courts have sustained plaintiffs' position. *See American Medicorp, Inc. v. Schweiker,* 690 F.2d 750 (9th Cir. October 22, 1982); *Spokane Valley General Hospital, Inc. v. United States,* 688 F.2d 771 (Ct. Cl. September 8, 1982). These opinions demonstrate that there is a split among the circuits on this question

but that does not mean, as plaintiffs contend, that there has been a change in the "legal atmosphere." This Court would be hard pressed to rule that such a change in the legal atmosphere has taken place in the mere nine month period since the District of Columbia opinion.

Under this general theory, plaintiffs also argue that significant factual changes warrant an exception to the doctrine of collateral estoppel. The prior *Humana* decision relied heavily on a District of Columbia Court of Appeals opinion in *Richey Manor, Inc. v. Schweiker,* No. 81-1045, (July 30, 1982). That case involved a one hundred percent stock acquisition which was *not* followed by a merger or dissolution, although in dicta, the Court expressly rejected the position asserted by plaintiffs in this action. Plaintiffs now try to argue that the *Richey Manor* precedent does not apply to this case where a merger did not follow the stock purchase. This a thinly veiled attempt to encourage this Court to rule that the District of Columbia Court misapplied the *Richey Manor* decision, something which this Court declines to do.

Finally, plaintiffs argue that "special circumstances" militate against applying collateral estoppel. It is true that where a federal agency is a party to litigation, a rigid application of collateral estoppel may not be appropriate. *See American Medical International, Inc. v. Secretary of HEW,* 677 F.2d 118 (D.C. Cir. 1981). This is especially true since the Supreme Court has done away with the mutuality requirement in collateral estoppel cases. *Parkland Hosiery Co. v. Shore,* 439 U.S. 322, 99 S.Ct. 645, 58 L.Ed.2d 552 (1979). As the Court in *American Medical* stated:

> To allow nonparties . . . to win simply on the basis of an estoppel would mean that we

> simply and uncritically bind ourselves to follow another court's interpretation of a federal statute . . . [T]he first court to hear a case raising a public law issue . . . would – if it ruled against the Government – rigidify the law to be applied by every court in every case presenting that issue. 677 F.2d at 121.

Such a result would foreclose inquiry by other circuits. Healthy debate and conflict among the circuits would then be precluded. *Id.* at 122.

This potential problem does not constitute a "special circumstance" to the benefit of the plaintiffs in this action, however. These plaintiffs are estopped because they were plaintiffs in the prior lawsuit. Nonparties to that case are not estopped from litigating the same issue in other circuits. Indeed, it is clear from the current split among the circuits on this issue that the decision of the first court to consider this question has not pre-empted the field.

[*Conclusion*]

However, because the parties in the prior *Humana* decision and this action are the same, the doctrine of collateral estoppel should be invoked. As the District of Columbia Court of Appeals in *American Medical* stated: "If the Government is litigating with the same adversary in both cases, estoppel will petrify the law only as to that one party – obviously not an unjust result – and accordingly will work no preclusion generating national shockwaves." 677 F.2d at 124.

Plaintiffs voluntarily chose to litigate this issue in the District Court for the District of Columbia. They lost. The

doctrine of collateral estoppel acts to bar the relitigation of this issue as far as these parties are concerned.

– Footnotes –

[1] "Part A" of the Act, 42 U.S.C. §§ 1395c-1395i-2, sets forth the reimbursement scheme.

[2] Defendant's Memorandum In Support of Motion to Dismiss and for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment at p. 11.

[3] A provider seeking to overturn a decision of the PRRB or the Secretary may obtain judicial review in federal district court in the district in which the provider is located or in the District of Columbia. 42 U.S.C. § 1395oo(f)(1).

(2)

No. 90-1321

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In the Supreme Court of the United States

OCTOBER TERM, 1990

NATIONAL MEDICAL ENTERPRISES, INC.,
d/b/a THROUGH VARIOUS WHOLLY OWNED
HOSPITAL SUBSIDIARIES, PETITIONER

v.

LOUIS W. SULLIVAN,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the court of appeals correctly refused to uphold, on collateral estoppel grounds, petitioner's challenge to the Secretary's disallowance of Medicare reimbursement for stock maintenance costs.

2. Whether the Secretary properly disallowed petitioner's claim for Medicare reimbursement for stock maintenance costs.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 916 F.2d 542. The opinion of the district court (Pet. App. 16-23) is unreported.

JURISDICTION

The judgment of the court of appeals was entered October 10, 1990. A petition for rehearing was denied November 29, 1990. Pet. App. 55. The petition for a writ of certiorari was filed February 22, 1991. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under the Medicare program, the Secretary of Health and Human Services is required to reimburse "providers of service," *i.e.*, hospitals, for reasonable costs "necessary in the efficient delivery of needed health services" to Medicare patients. 42 U.S.C. 1395x(v)(1)(A). The Secretary's implementing regulations provide that to qualify for reimbursement, the provider's costs must be "necessary and proper," 42 C.F.R. 405.451(b) (1985), and "directly or indirectly related to patient care," 42 C.F.R. 405.451(c) (1985).[1] Since 1973, the Secretary has taken the position that under the governing statutory scheme,

> [t]he foliowing types of costs relevant to the proprietary and equity interest of the [provider's] stock holders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailings of proxies, stock transfer agent fees, stock exchange registration fees, stock broker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

Pet. App. 6 (quoting Provider Reimbursement Manual § 2134.9 (1973)); see Pet. App. 6 n.1.

2. Petitioner owns acute care and convalescent hospitals. As a publicly held corporation, petitioner incurs a variety of so-called "stock maintentance

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[1] As the court of appeals pointed out, see Pet. App. 5, those regulations have recently been redesignated as 42 C.F.R. 413.9(b) and (c).

costs," namely, "stock transfer agent fees, stock and exchange registration fees and costs attributable to SEC filings, stockholder meetings, annual reports to stockholders, and institutional public relations related to stock and financial matters." Pet. App. 4. For a number of years, petitioner has tried to pass these costs through its separately incorporated hospitals and on to the Medicare program. The Secretary, however, has denied reimbursement.

In particular, petitioner and three of its subsidiary hospitals sought reimbursement for stock maintenance costs incurred during fiscal year 1973. The Secretary denied petitioner's claim, and petitioner sought review in the Claims Court. In 1986, the Claims Court reversed the Secretary's decision, holding that stock maintenance costs were subject to reimbursement under the Medicare program as reasonable expenses related to patient care. *National Medical Enterprises, Inc.* v. *United States*, 11 Cl. Ct. 329 (1986) (*NME I*); see Pet. App. 5.[2]

3. Thereafter, petitioner, on behalf of the three subsidiaries involved in the Claims Court litigation and fifteen additional subsidiaries, sought reimbursement for stock maintenance costs incurred during fiscal years 1974 through 1979. After an agency review process, the Secretary denied petitioner's claim. The Secretary held that "stock maintenance costs were incurred primarily for the benefit of present and future stockholders, not Medicare patients, and thus were not 'reasonable costs' related to patient care under the Medicare Act." Pet. App. 6. Moreover, the Secretary concluded that reimbursement was

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[2] *NME I* applied (11 Cl. Ct. at 332-333) Court of Claims precedent established by *AMI-Chanco, Inc.* v. *United States*, 576 F.2d 320 (1978).

unavailable in light of the governing Provider Reimbursement Manual § 2134.9 (1973).

Petitioner then filed this federal court action challenging the Secretary's denial of reimbursement.[3]

4. On cross-motions for summary judgment, the district court in June 1989 reversed the Secretary's decision. Pet. App. 16-23. The court determined that "[s]tock maintenance costs are necessarily incurred by providers in connection with equity financing. Such costs are indistinguishable from costs incurred by providers in connection with debt financings, * * * which are reimbursed by the Secretary." *Id.* at 22. The court concluded that "[t]here is no rational basis for disallowing the costs incurred by providers in connection with equity financings while allowing similar costs of debt financings." *Ibid.* Accordingly, the court held that "under the Medicare statute and regulations, stock maintenance costs must be allowed." *Ibid.*

5. The court of appeals reversed. Pet. App. 1-15. As a threshold matter, the court refused to hold that under the doctrine of collateral estoppel, the issue had been conclusively determined in petitioner's successful challenge to the Secretary's decision in *NME I*. The court concluded that the requisite "mutuality" was lacking, because "this lawsuit is grounded on

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[3] As the Claims Court pointed out in *NME I*,

> jurisdiction to review final decisions of the Provider Reimbursement Review Board or any reversal, affirmance, or modification by the Secretary, *for accounting periods ending on or after June 30, 1973*, rests with the district court for the federal district in which the provider is located or in the District Court for the District of Columbia.

11 Cl. Ct. at 332-333 n.4 (emphasis added); see 42 U.S.C. 1395oo note (1976).

the claims of eighteen-wholly owned subsidiaries—fifteen of which were not involved in the prior action." *Id.* at 8. As the court explained:

> Allowing a home office to establish mutuality merely by holding itself out as the "representative" of multiple subsidiaries would open the door for home offices with providers in multiple states to secure a favorable judgment in one circuit, then bind the government to that judgment in other circuits.

Id. at 9. Such a result, the court reasoned, would run counter to this Court's admonition in *United States* v. *Mendoza*, 464 U.S. 154, 160 (1984), that nonmutual collateral estoppel against the government "would substantially thwart the development of important questions of law by freezing the first final decision rendered on a particular legal issue." Pet. App. 9.

The court rejected petitioner's invitation to excuse the lack of mutuality on the ground that petitioner "and the fifteen subsidiaries that were not involved in [*NME I*] were in privity with each other." Pet. App. 9. The court recognized that "collateral estoppel is inappropriate where, as here, it would be 'unfair' to the defendant." *Ibid.* (quoting *Parklane Hosiery Co.* v. *Shore*, 439 U.S. 322, 331 (1979)). The court pointed to the fact that the courts of appeals "consistently have denied providers Medicare reimbursement for stock maintenance costs," Pet. App. 10, see *Humana, Inc.* v. *Heckler*, 758 F.2d 696, 700 (D.C. Cir. 1985), cert. denied, 474 U.S. 1055 (1986); *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, 317 (5th Cir.), cert. denied, 469 U.S. 823 (1984); *American Medical Int'l, Inc.* v. *Secretary of HEW*, 677 F.2d 118, 124 (D.C. Cir. 1981). Accordingly, the court

concluded that "allowing [petitioner's] subsidiaries in the present case to be reimbursed would unduly privilege them vis-a-vis providers in similar circumstances." Pet. App. 10.

Turning to the merits, the court of appeals held that "the Secretary's decision to deny reimbursement for stock maintenance costs rested on a rational basis." Pet. App. 10. The court found that "[a]lthough stock maintenance programs may influence the corporate form, they have little bearing on its substance, the provision of patient services." *Id.* at 11. The court also noted that "stock maintenance programs are directed primarily at present and future stockholders, rather than at the provision or improvement of patient services." *Ibid.* "Under these conditions," the court concluded, "it was reasonable for the Secretary to deny [petitioner's] subsidiaries reimbursement." *Id.* at 11-12.

ARGUMENT

1. Petitioner contends (Pet. 9-15) that the court of appeals erred in refusing to uphold its claim of collateral estoppel. But the court's rejection of that claim was proper, and presents no question warranting this Court's review.

a. This Court has held that "nonmutual offensive collateral estoppel simply does not apply against the Government in such a way as to preclude relitigation of issues." *United States* v. *Mendoza*, 464 U.S. 154, 162 (1984). Since "this lawsuit is grounded on the claims of [petitioner's] eighteen-wholly owned subsidiaries—fifteen of which were not involved in the prior action," Pet. App. 8, there is no mutuality at least with respect to those 15 subsidiaries.

Nor can petitioner's participation in this action establish the requisite mutuality since it is not a

proper party. This action challenges the Secretary's denial of reimbursements claimed by petitioner's 18 separately incorporated subsidiary hospitals. Under the terms of 42 U.S.C. 1395oo(f)(1), only the "providers of services" to Medicare beneficiaries—the hospitals—"have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary."[4] That statutory provision incorporates the settled principle that a parent firm does not have standing to bring an action as the alter ego of its subsidiaries. See *Schenley Distillers Corp* v. *United States*, 326 U.S. 432, 435 (1946). As the Second Circuit has explained:

> Where a parent corporation desires the legal benefits to be derived from organization of a subsidiary that will function separately and autonomously in the conduct of its own distinct business, the parent must accept the legal consequences, including the inability later to treat the subsidiary as its alter ego because of certain advantages that might thereby be gained. In short, the parent cannot "have it both ways."

In re Beck Industries, Inc., 479 F.2d 410, 418, cert. denied, 414 U.S. 858 (1973). Accordingly, petitioner's attempted sleight of hand in filing as the named plaintiff in the courts below cannot establish the mutuality necessary to invoke collateral estoppel against the government.

b. In any event, collateral estoppel on the basis of *NME I* would be unavailable even if petitioner had

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[4] The statute defines "provider of services" as "a hospital, skilled nursing facility, or home health agency." 42 U.S.C. 1395x(u).

satisfied the element of mutuality.[5] Such preclusive effect is inappropriate where "controlling facts or legal principles have changed significantly since [the prior action]." *Montana* v. *United States*, 440 U.S. 147, 155 (1979). The Court has summarized the basis of this limitation in the context of federal income tax litigation:

> A taxpayer may secure a judicial determination of a particular tax matter, a matter which may recur without substantial variation for some years thereafter. But a subsequent modification of the significant facts or a change in the development in the controlling legal principles may make that determination obsolete or erroneous, at least for future purposes. If such a determination is then perpetuated each succeeding year as to the taxpayer involved in the original litigation, he is accorded a tax treatment different from that given to other taxpayers of the same class. As a result, there are inequalities in the administration of the revenue laws, discriminatory distinctions in tax liability, and a fertile basis for litigious confusion. * * * Such consequences, however, are neither necessitated nor justified by the principle of collateral estoppel. That principle is designed to prevent repetitious lawsuits over matters which have once been decided and which have remained substantially static, factually and legally. It is not meant to create vested rights in decisions that have become obsolete or erroneous with time, thereby causing inequities among taxpayers.

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[5] Thus, the fact that three of petitioner's subsidiaries participated in both *NME I* and the present action does not call for application of collateral estoppel as to their claims for reimbursement.

Commissioner v. *Sunnen*, 333 U.S. 591, 599 (1948); see generally Restatement (Second) of Judgments § 28(2), Comment *c* (1982).

The principle enunciated in *Sunnen* applies with particular force in this case, since petitioner—like the taxpayer in *Sunnen*—is claiming an entitlement to federal funds based on the result of previous litigation. First, there have been significant changes in the pertinent legal landscape since the Court of Claims issued its decision in *AMI-Chanco*, which the Claims Court followed in *NME I*. (See note 2, *supra*.) Congress has divested that court of jurisdiction over Medicare reimbursement claims accruing after June 30, 1973. See note 3, *supra*. Moreover, the decision in *AMI-Chanco*, followed in *NME I*, has not prevailed. The courts that have assumed the jurisdiction previously exercised by the Claims Court have consistently upheld the Secretary's decision to deny reimbursement for stock maintenance costs. See *Humana, Inc.* v. *Heckler*, 758 F.2d 696, 700 (D.C. Cir. 1985), cert. denied, 474 U.S. 1055 (1986); *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, 317 (5th Cir.), cert. denied, 469 U.S. 823 (1984); *American Medical Int'l, Inc.* v. *Secretary of HEW*, 677 F.2d 118, 124 (D.C. Cir. 1981).

Second, the changed circumstances preclude application of collateral estoppel in order "to avoid inequitable administration of the laws." Restatement (Second) of Judgments § 28(2), at 273 (1982). In light of the prevailing case law, providers other than petitioner's subsidiaries may not obtain reimbursement for stock maintenance costs. As this Court has recognized, collateral estoppel "is not meant to create vested rights in decisions * * * thereby causing inequities among [similarly situated parties]." *Com-*

missioner v. *Sunnen*, 333 U.S. at 599. To borrow the D.C. Circuit's apt phrasing, "[t]o permit an estoppel here would do exactly that." *American Medical Int'l, Inc.* v. *Secretary of HEW*, 677 F.2d at 124.[6]

2. Petitioner also contends (Pet. 15-21) that the Secretary erred in disallowing its claim for Medicare reimbursement for stock maintenance costs. The governing statute provides Medicare reimbursement only for those costs reasonably "related to patient care," and prohibits reimbursement for costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x(v)(1)(A). Under that standard, the Secretary's decision is unexceptionable.

a. Stock maintenance costs, such as those incurred by petitioner, are not sufficiently related to patient care. SEC filings, stock transfers, and stock registrations protect the interests of shareholders; such activities are not meant to benefit patients. Similarly, shareholder meetings and annual reports—by definition—are geared to shareholders and investors. As the D.C. Circuit has recognized:

> [S]tock maintenance costs * * * serve to protect the shareholders and to enhance their investment. While the indirect effect of stock maintenance activities may sometimes benefit medical services, the connection is too indirect.

Humana, Inc. v. *Heckler*, 758 F.2d at 700; accord *Sun Towers, Inc.* v. *Heckler*, 725 F.2d at 328. Accordingly, the Secretary properly determined (Pet. App. 51) that petitioner's hospitals here did not re-

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[6] Petitioner therefore errs in relying (Pet. 11) on *Humana, Inc.* v. *Schweiker*, No. 82-3415 (M.D. Tenn. 1983) (Pet. App. 106-118), since that case did not involve the sort of changed legal circumstances that preclude the application of collateral estoppel.

ceive any patient-care-related benefits as a result of petitioner's incurring stock maintenance costs.

Moreover, stock maintenance costs are not necessary to the efficient provision of needed health care services. Although "[s]tock maintenance costs are necessary for a corporation to exist, * * * medical service can be provided without the corporate form." *American Medical Int'l, Inc.* v. *Secretary of HEW*, 466 F. Supp. 605, 613 (D.D.C. 1979), aff'd, 677 F.2d 118 (D.C. Cir. 1981); accord *Humana, Inc.* v. *Heckler*, 758 F.2d at 700; *Sun Towers, Inc.* v. *Heckler*, 725 F.2d at 327. Patient care services can be—and generally are—provided by hospitals that operate outside the publicly held corporate structure, and thus do not incur stock maintenance costs. In these circumstances, the Secretary properly "found [such costs] to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x(v)(1)(A).

b. In the face of this straightforward application of the governing statute, petitioner claims (Pet. 16) that the Secretary's policy is irrational because he reimburses those costs incurred to organize a corporate entity. That view is mistaken.

> The primary purpose of all costs incurred at the creation of the entity is to bring into existence a provider of medical services. As the entity survives, the stock maintenance costs have as their primary purpose the protection of stockholder interests in investment. This is a rational distinction justifying the different treatment accorded the different costs by the Secretary.

American Medical Int'l, Inc. v. *Secretary of HEW*, 466 F. Supp. at 615; see *Sun Towers, Inc.* v. *Heckler*, 725 F.2d at 327. Stock maintenance costs, unlike those costs expended to create the corporate entity, generate

no new capital for the corporate owner or provider of health services.

In a similar vein, petitioner points (Pet. 17-18) to the Secretary's policy of reimbursing interest expenses and other costs associated with debt financing. The Secretary reimburses those costs only when the loan is necessary and has a "purpose reasonably related to patient care." 42 C.F.R. 405.419(b)(2)(ii) (1985) (redesignated as 42 C.F.R. 413.153). As explained above, the activities covered by stock maintenance costs fail to measure up to that standard.

c. Petitioner also asserts (Pet. 15-16) that the decision below may not be squared with the Court of Claims' decision in *AMI-Chanco* (followed by the Claims Court in *NME I*). But any such conflict has no current significance, since Congress has divested the Claims Court (and thus the Federal Circuit, successor to the Court of Claims) of jurisdiction over the reimbursement issue. See note 3, *supra*. Accordingly, further review by this Court is not warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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In The

Supreme Court of the United States

October Term, 1990

NATIONAL MEDICAL ENTERPRISES, INC.,

Petitioner,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITIONER'S REPLY MEMORANDUM

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In his Brief in Opposition the Secretary makes a variety of arguments, most of which are adequately refuted by NME's Petition. However, two arguments pertaining to the collateral estoppel issue require the filing of this brief reply memorandum. Those arguments are (1) that NME is not a "proper party" in these proceedings (Opposition at 6-7); and (2) that there have been significant changes in the law since the issuance of the Court of Claims decision in *AMI-Chanco* and those changes preclude application of collateral estoppel to avoid "inequitable administration of the laws" (Opposition at 7-10).

With respect to the improper party allegation, the Secretary suggests that by naming NME as the plaintiff in this litigation NME used "sleight of hand" to try to establish the mutuality necessary to invoke collateral estoppel against the government. (Opposition at 7.) Nothing could be less accurate. If there has been any sleight of hand, it has been on the part of the Secretary who engaged in forum shopping to avoid the impact of the Claims Court's adverse decision in the previous NME litigation. The Secretary would not be in the position of trying to avoid collateral estoppel if he had appealed the adverse Claims Court decision and, if necessary, eventually had sought review of the corporate maintenance cost issue before this Court. Rather than following this appropriate procedure, the Secretary chose to ignore the Claims Court decision and forced NME to relitigate the issue in another Circuit.

NME is indeed the appropriate party to have pursued this matter through the courts. NME incurred the corporate maintenance costs in the first place. As the home office for its wholly owned hospital subsidiaries,

NME was entitled to pursue reimbursement for the corporate maintenance costs in issue on behalf of its providers.

Indeed, pursuant to 42 U.S.C. Section 1395oo(f)(1), NME was required to pursue the corporate maintenance costs issue on behalf of its providers as a "group appeal." 42 U.S.C. § 1395oo(f)(1). The Secretary designated NME as the appropriate party before the Provider Reimbursement Review Board and before the Health Care Financing Administration, the entity which reviews final PRRB decisions on behalf of the Secretary. (App. at 26, 47.)

NME initiated the judicial review proceedings in the District Court on behalf of its wholly owned providers. The Secretary made no objection to NME doing so in its answer to NME's complaint and, in fact, expressly admitted that NME was the home office for each provider in question. Complaint and Answer, ¶ 4. Importantly, the providers were expressly incorporated into the complaint by NME by reference, Complaint, ¶ 4, and Exhibit 1 to Complaint.[1]

Moreover, the statutory provision relied on by the Secretary to argue that NME is not a proper party, 42

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[1] Only in a last-minute attempt to try to avoid the impact of collateral estoppel did the Secretary assert that NME was not a proper party before the District Court. Had the Secretary appropriately and timely raised the issue in the District Court in his Answer or through some type of motion, the District Court could have reviewed the issue. At worst, NME would have been required simply to amend its Complaint to add to the caption of the Complaint the names of the providers referred to and incorporated in paragraph 4 of the Complaint.

U.S.C. § 1395oo(f)(1), simply addresses the venue issue for judicial review of Medicare decisions and does not resolve the "capacity" issue. The identity of the providers only determines the appropriate venue for subsequent judicial review.

The second assertion, *i.e.*, there have been changes in the law which preclude application of collateral estoppel, is equally baseless. The governing Medicare statute, regulations and manual provisions have not changed in substance with respect to corporate maintenance costs since the United States Court of Claims issued its decision in *AMI-Chanco* and certainly have not changed since the Claims Court issued its decision in favor of NME. The material facts pertaining to NME's corporate maintenance costs for the 1973 fiscal year are identical to the facts applicable to the subsequent fiscal years, the years in question. Indeed, the Secretary has never before asserted or relied on any argument that there has been a change in the law or the facts.

The Secretary's assertion that there "have been significant changes in the pertinent legal landscape" (Opposition at 9) reflects nothing more than the fact the Courts of Appeals for the D. C. Circuit and the Fifth Circuit issued decisions contrary to the United States Court of Claims decision in *AMI-Chanco*. This disagreement among the circuits does not constitute significant changes in the law but simply represents a difference of opinion on how the law should be interpreted. If anything, this fact simply confirms why the Court should grant certiorari.

Finally, the application of collateral estoppel against the government in this case does not help to avoid inequitable administration of the law. Rather, its application will foster uniform application of law. If the Court of Appeals' decision in this case is not overturned, some of NME's hospitals will have received reimbursement for corporate maintenance costs while others will not have. If collateral estoppel is applied all of NME's hospitals will be treated uniformly. The fact that NME's hospitals will receive reimbursement for corporate maintenance costs while other unrelated hospitals might not simply reflects that NME prevailed in its initial lawsuit against the Secretary while these other hospitals failed. Indeed, this fact also shows why this Court should involve itself in the resolution of the merits of the validity of the Secretary's corporate maintenance costs. It certainly does not provide support for abandoning collateral estoppel.

In conclusion NME continues to urge the Court to grant its Petition for Certiorari.

DATED: April 24, 1991

Respectfully submitted,

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